MISSOURI

DIVISION OF WORKERS' COMPENSATION

OPERATIONS MANUAL

Updated February 1, 2005

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The information contained in this operations manual as well as a list of frequently asked questions, contact information, forms used by the Division of Workers Compensation, rules of the Division's eight adjudication offices and other information can be found on the Divisions web site at www.dolir.mo.gov/wc.

DIVISION OF WORKERS' COMPENSATION OVERVIEW

The Missouri Workers' Compensation Law became effective on November 2, 1926. The Division of Workers' Compensation is responsible to administer the law. The Division's primary functions are to provide a forum for and assist in the prompt and equitable resolution of cases of work-related injury and occupational diseases, and to collect and store data relating to cases.

The basic concept of the law today remains the same as it was over 75 years ago--the compensation for wage loss, permanent disability, death and medical treatment of injured workers is the responsibility of the employment that created the need while at the same time protecting employers from liability in civil actions. As the economy advanced with industrial development, so did the law, with a series of amendments that increased weekly compensation, added new benefits for injured workers and new protections for employers.

Operations

The Division's administrative organization is designed to promote a fair and amicable settlement between the parties, resulting in a minimum of formal litigation. As the chief administrative officer, the director guides the affairs of the Division. Assisting in the administrative duties are the deputy director, chief legal advisor and the chief administrative law judges assigned to local offices.

The Division's central office is in Jefferson City. In addition, mediations, hearings and conferences are held in eight (8) full-time adjudication offices located throughout the state: Cape Girardeau, Jefferson City, Joplin, Kansas City, Springfield, St. Charles, St. Joseph, and St. Louis. Adjudication proceedings are also conducted in 38 separate locations, in addition to the permanent local offices. Legal staff consists of 26 administrative law judges, aided by 22 legal advisors. The Division employs additional staff of 126 full-time employees to administer the workers' compensation law and assist injured workers and employers.

The operating expense of the Division is funded by a tax not to exceed two percent on employer's net compensation insurance premiums and on calculated equivalent premiums of self-insurers.

Compensation and Medical Benefits

The maximum weekly benefit amount rose from $20 in 1926 to the present level of 2/3 of the injured worker's average weekly wages, up to the limit of 105% of the state's average weekly wage (SAWW), which is computed annually. Medical benefits are unlimited during the complete period of recovery. If all benefits are not paid within two years of the injury, or the date of last payment made for benefits, the employee must file a claim to preserve his or her rights.

Second Injury Fund

In 1943, a revision to the workers' compensation law established the Second Injury Fund to limit liability of the employer for subsequent injuries resulting in permanent total disability. An employee who suffers from a prior injury, and the combined effect of the current work-related injury results in increased permanent disability, the employer (at the time of the most current injury) is liable for only that injury, and the remaining compensation due is paid from the Second Injury Fund (Fund).

The Fund's coverage expanded in 1955, to include any permanent-partial disability compounded by a subsequent injury. Additional amendments were made over the years to the law with the most significant in 1993. The liability of the Fund is now limited by a requirement that the prior injury and the current injury meet a minimum disability threshold.

Additional changes in the law provide for payments of medical expenses, burial expenses or death benefits for employees or their dependents of employers not having insurance when required to by law. The Fund also pays a supplement of $40 per week to individuals undergoing physical rehabilitation for work injuries.

The Second Injury Fund is financed by a surcharge on workers' compensation insurance policy net premiums and calculated equivalent premiums, in the case of self-insured employers

Employers Covered

All employers having five or more employees must comply with the workers' compensation law. Employers with four or fewer employees may elect to be covered in order to protect their assets by the exclusive remedy of the workers' compensation law. In 1990, coverage was expanded to include employers in the construction industry with one or more employees. Jobs specifically exempted from the law include: farm labor; domestic servants in a private home; certain family members; qualified real estate agents; door-to-door sellers; inmates that work on behalf of the state or local government; volunteers federal tax-exempt employers; and school-employed sports officials.

ADMINISTRATION

File Copies and Certified Records

According to Division policy, any request for copies of documents must be made in writing to the Division. Paper files may be transferred to the appropriate local offices for inspection. The basis for the release of information is established by § 287.380.3, RSMo. The First Report of Injury, and any subsequent medical reports contained in the case file are confidential records. Please refer to Sunshine Requests in the Legal Section of this manual for further information.

A party to the case or that party's attorney has access to all records contained in the workers' compensation file maintained by the Division. Confidential information will also be released in response to a subpoena issued in another workers' compensation case or a civil action. Finally, confidential information will be released if the employee signs a general release of information, directed to the Division of Workers' Compensation, authorizing the release of records maintained by the Division. This release must be signed and notarized. A stale-dated release will be questioned to determine its current validity.

Documents maintained by the Division of Workers' Compensation can be certified for admission in another proceeding, as the records maintained in the original compensation case. However, the Division cannot certify these records as business records pursuant to § 490.692, RSMo. The certification statute for business records requires verification that the Division prepared the entries maintained in the records at or near the time of the event described in the document. Since most records are prepared by parties other than the Division and then filed with the Division, the record cannot be certified for accuracy of the information contained in the documents. However, the Division will comply with the request for certification of records as true and accurate copies of records maintained in the Division file. Certified records are admissible in evidence under § 287.590, RSMo.

The cost for copies is $.50 per page and $1.00 for certification per file. If you have any questions, please call the Records Clerk at 573-526-3536. Requests for copies of records or certified records should be directed to:

Records Clerk
Division of Workers' Compensation
PO Box 58
Jefferson City, Missouri 65102-0058

Awards/Transcripts

The Division is responsible for processing awards and appeals to the Labor and Industrial Relations Commission. The most important concern is that the proper party is identified in the case, and that addresses are accurate so notice of awards can be mailed promptly to the parties. When the case is appealed, the employee is not charged for his or her copy of the transcript, however, the employer and insurance company must pay $.30 per page for

the transcript. Requests for transcripts in cases not appealed will be prepared on an as available basis by the court reporter. All transcripts for appealed cases are given priority for completion. The party requesting the transcript, in an unappealed case, must pay the cost of copies.

Authorization to Release Information (Form 43)

The Division also handles requests for information not necessarily contained in Division files. The Division authorizes the release of medical information to parties to the case based on § 287.140.7, RSMo. The Form 43 authorizes the release of medical information, from a treating or rating physician, to a party to the case. The request is processed through the Division and the Authorization Form (Form 43) is sent to the requesting party to use in obtaining medical records.

The Form 43 instructs the medical provider that only records relating to the current injury be released. Prior to release, to ensure it is the correct injury, a specific description of the injury will be verified with records filed with the Division. The party requesting the information must be a party to the workers' compensation case. There is no fee for the authorization; however, the medical provider may charge a fee to the requesting party for producing the records. Other medical records must be obtained by subpoena, or by an employee's release authorization.

File Room

Individual case files and exhibits from paperless files are maintained in a central file system for referral to the various offices or units as needed in the adjudication and claims process. The Division began using paperless filing through electronic document storage for all injuries that occurred on or after January 1, 1994. Paper case files are maintained for injuries before that date.

The file room clerk is responsible for all files and the file room. This individual is also responsible for filing supplementary records in the case folders and sending files to archives for storage when closed. All paper files remain in the Division file room for six months following settlement or closure. The file is then sent to archives for storage. The file clerk also retrieves files from archives for review or action by the Division staff and distributes them each day to the requesting party. A record of file location is maintained at archives to permit retrieval of a file at a later time, when needed.

Paper files on a case assigned to the adjudication staff in any of eight workers' compensation adjudication offices are transferred from the central office to the respective division adjudication office until the case is resolved. Correspondence on these files is sorted by file locations and forwarded to the proper office and placed in the related case file. All location transfers are kept in the case automation system.

Files for injuries prior to 1986 are not usually in the Division's computer system. If a pre-1986 file is needed for any reason, it is entered in the computer system and transferred from

the file room as noted above. Most pre-1986 cases involving the payment of ongoing benefits have been entered in the computer system.

The central file room retains case files on permanent total disability, death cases with payments to dependents, structured settlements or annuities, and permanent partial disability cases requiring continued replacement of prosthetic devices or continuing medical treatment. The oldest of these cases dates back to 1937, and is only one of approximately 1,600 files in this category.

Although paperless files have been established in the Division data imaging system, it will be several years before all paper files are closed. In addition, not all exhibits and evidence presented on cases, in hearings and to the Labor and Industrial Relations Commission for review, can be imaged. This information must be otherwise maintained for use as needed by the Division for 10 years. Parties may also request the return of exhibits after the award has become final.

INJURY PROCESSING

The Division is responsible for receiving and processing all the documents and information pertaining to a reported work-related injury. Division Injury Processing staff are responsible for data entry and case review. They are responsible for: maintaining injury files; processing from the First Report of Injury (Form 1, WC-1-EDI), the Claim for Compensation (Form 21, WC-21), the Answer to the Claim for Compensation (Form 22, WC-22) and other required forms; collecting medical and return-to-work information; and contacting insurance companies and employers to update case files. Additional Division staff is responsible for scanning and indexing all documents into the proper paperless file. In order to accomplish these responsibilities and gather the necessary information, the Division employs the use of several forms and form letters. All forms may be found on the Division's web site at www.dolir.mo.gov/wc on the Forms and Brochures page.

Mail Opening and Sorting

All incoming mail is date-stamped on the date received by the Division. The date-stamp, not the postmark date, is the date of receipt of the document. Documents meeting imaging requirements are then imaged to electronic file. Documents not meeting imaging requirements are reviewed and returned. Approximately 2,000 pieces of mail are received daily.

First Report of Injury – (FROI)

Every work-related injury and occupational disease, occurring in Missouri, except "first aid" cases not requiring medical treatment must be reported to the Division. The First Report of Injury form (FROI) is used to file the information.

The injury must be reported to the Division on the FROI within ten days of the date the employer has actual notice of the injury. The employer must report all injuries requiring medical treatment to its insurance carrier or third party administrator within five days of the date the employer has actual notice of the injury. The insurance carrier, third party administrator or self-insured employer or trust has the remaining five days or the remaining time up to ten days from the date the employer was aware of the injury or the employee notified the employer of the injury, to report the injury to the Division.

In July 1995, the Division of Workers' Compensation began receiving FROIs by electronic data interchange (EDI). Data from the FROI is transmitted directly from insurance carriers, third party administrators and self-insured employers to the Division's computer database. No paper is exchanged; however, the FROI must meet all edit requirements. The Division of Workers' Compensation and the reporting entities save substantial time and money by using electronic reporting. Currently, the Division receives over seventy percent of First Reports of Injury electronically.

When an injury report is received in electronic format it goes through several processing steps. Below is a summary of each step:

- Each FROI is reviewed to determine if all mandatory fields have the required information. If the FROI is incomplete it is rejected and will be electronically returned to the sender with the appropriate error codes.

- If the FROI has information that does not match Division information or has certain other errors, it will be put in a review bucket. Division staff will review the FROI to determine whether it will be accepted or rejected. Once accepted, data on the FROI is downloaded in the Division's database and the computer assigns the injury number.

- Once the FROI is accepted, it will be acknowledged to the sender and all necessary form letters are automatically generated. These letters are as follows:

  - **WC1-1 – First Report of Injury Acknowledgment –** This is the acknowledgement of receipt of the FROI and includes the Division injury number assigned to that injury. This document is electronically sent to the insurer, the third-party administrator or self-insured employer or trust that filed the FROI.

  - **WCNOR – Notification of Rights –** This letter is sent to all injured employees when the Division receives information there is lost time or permanent disability to notify them of their rights under the workers' compensation statute. The letter is sent when the employee files a Claim or the Division receives information indicating this is an indemnity case.

  - **WCMED – Medical Only –** This letter is sent to all injured employees with no lost time or permanent disability indicated on the FROI that has been filed. It also advises them of their rights under the workers' compensation statute. This letter is sent 120 days after the receipt of the FROI.

  - **WC14 – Information Requests –** This letter is sent to the employer/insurer or third party administrator requesting additional information required for processing of the case, which may not have been available at the time the FROI was submitted. The first request letter is sent 90 days after the injury is reported to the Division and periodically after that, depending on the case.

Paper Forms

The Division receives a significant amount of information on paper forms submitted by the insurance companies, third party administrators, or self-insured employers or trusts. There are some general guidelines to follow when submitting paper documents.

1. The print font size and print quality must be adequate for the image system. The minimum font size is 10. Any documents that are not of a quality to be scanned into the image system will be returned.
2. The injury number must be listed on all subsequent correspondence sent to the Division.
3. Handwritten documents will be rejected and returned. The only exception is a Claim for Compensation filed by an unrepresented employee.

Common Mistakes or Problems – First Report of Injury (FROI)

FROIs are not considered properly filed until all mandatory information is provided, the information is correct and the Division assigns an injury number. The most common problems on the FROI are as follows:

1. Employer's address not complete.
2. Federal Employer Identification Number (FEIN) not provided.
3. Carrier's name and address not complete.
4. Carrier FEIN not provided or is incorrect.
5. SIC or NAICS code not provided.
6. Third party administrator (TPA) listed rather than the insurance company.
7. TPA FEIN not provided or incorrect.
8. Date of birth not provided or year not correct.
9. Social security number not provided, incomplete or incorrect.
10. Employee's address not complete.
11. National Council on Compensation Insurance (NCCI) classification code not provided.
12. Rate of pay not provided or incorrect wage period is listed.
13. No specific date of injury.
14. Date employer notified not provided.
15. Type of injury code not provided or incorrect.
16. Part of the body injured code not provided or incorrect.
17. Cause of injury code not provided or incorrect.
18. Initial treatment information not provided.
19. Zip codes of accident location not provided.

Notice of Commencement/Termination of Compensation Payments (WC-2)

The employer or insurer must complete and file the Notice of Commencement/ Termination of Compensation Payments (WC-2) when the employee's disability lasts longer than three days. No compensation is payable for the first three days of disability during which the employer is open for the purpose of operating its business or enterprise, unless the disability lasts longer than 14 days. If disability lasts longer than 14 days, payment for the waiting period is made retroactively to the claimant from the date of injury. Compensation must be paid as the employee's wages were paid before the injury, but at least once every two weeks.

The Form WC-2 is required as soon as compensation begins, however, no later than thirty days from the first payment of compensation to the employee. If the case is compensable and if the injury results in a disability for which compensation is payable for less than two weeks, the employer should only file the Form WC-2 on completion of the temporary total disability period. It must be filed within ten days of the date of termination of compensation.

When the employer/insurer files the form after the final payment for temporary total or temporary partial disability is paid to an injured worker, it is reviewed to determine if the amount of payment is correct. If the calculation of benefits is found to be incorrect or the employee was not paid the correct amount, the employer/insurer is notified. If the amount

paid is correct, the data is entered and the case is routed for case review. Once the data entry is complete, the forms are scanned.

The WC-9 Medical Treatment Form is for medical reporting and is required from the employer/insurer when the initial medical treatment is provided and after the final medical treatment is provided. If the appropriate information is available when the lost time information is filed on the WC-2, the medical treatment form may be filed at the same time. The report is reviewed to determine if it is a final report or if further treatment is needed. The report data is entered in the Division's database. A determination is made if more data is needed, if the case can be closed, or if the case will be referred to a local Division adjudication office for a docket setting.

If the employee only receives the initial medical treatment, this can be reported on the form WC-9 as final medical treatment and the cost is reported. If the employee undergoes a course of treatment, a report should be filed at the beginning of the medical treatment and again after the final medical treatment is provided. If the employee receives additional medical treatment after the prior final medical treatment has been reported, the additional treatment should also be reported.

Completing the WC-2, Lost Time

1) Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

a) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

b) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

c) If the employee's wage is fixed by the week, that amount is the AWW;

d) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

    i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW.

    For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.

    The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274.

The AWW is $5,274/13=$405.69.

ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 and receives no compensation, such as sick or other leave, those days shall be subtracted from the denominator.

For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.

iii) Partial weeks of time missed by the employee do not count to change the denominator.

For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.

iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment.

For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50.

The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50.

The AWW is $3,055.50/8=$381.94.

e) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

2) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The employer/insurer will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

3) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. The employer/insurer will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and

there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. The employer/insurer will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

Common Mistakes or Problems with Receipt and Notice of Termination of Compensation (WC-2)

1. Dates indicated for the period when disability began (first date of payment) and date disability ended (last date for which payment was made) do not equal the reported total number of weeks of disability and amount of payments made.
2. If a waiting period is taken, and it is something other than the first three days the employer is open for the purpose of operating its business or enterprise, include that information on the form.
3. If there are breaks in the disability dates where the employee may have returned to work for a few days, the exact periods of disability are not correctly shown.
4. If any of the lost time was paid on a temporary partial disability, those dates are not reported separately from the dates temporary total disability was paid and the rate of compensation paid for temporary partial disability is not reported.
5. Failure to file the form when disability benefits terminate for any reason.
6. Failure to list the reason for termination of compensation.

Claim for Compensation (WC-21)

An injured worker files a Claim for Compensation (Claim) to initiate a contested case with the employer/insurer. A Claim is also filed to toll (stop) the statute of limitations from expiring; that is, stop it from running. The Claim is currently only accepted in paper format. Once the Division receives it, staff reviews the Claim and it is entered in the Division's database.

The Claim is reviewed to determine if it is complete and of suitable quality for imaging. Incomplete claims for compensation, or claims not of suitable imaging quality, are returned to the sender. If a claim is returned and re-filed, it is processed with the original filing date. If the Claim is complete, it is processed. The Division scans the original and the copies are sent to the employer, insurer and also to the Office of the Attorney General, if a Second Injury Fund claim is filed. If the injury was not reported by the employer/insurer, the computer assigns an injury number after all mandatory information is entered.

The Division requires the employee to file the original and three copies of the Claim. The Division uses the original and the copies are sent to the employer, insurer, and Office of the Attorney General, if applicable. If there is more than one insurer or one employer on the case, additional copies need to be filed. Employees file claims as notice that a dispute has arisen in the course of their injury with the employer or insurer.

Once the case information has been entered into the database, the computer will automatically generate the form letters that are necessary for each particular file. The letters are printed overnight. The most common letter is the "Acknowledgment of Claim for

Compensation". This letter is mailed to the employer and insurer, with a copy of the Claim. If the Division is unable to identity an insurance company for an employer named in the Claim, a letter is sent to the employer requesting the information.

After processing, the Claim forms are held until the next day for the required computer generated letters. The letters are then matched with the appropriate Claim copy and mailed to the parties. The Claim form is scanned and the original destroyed. All cases where a Claim is filed are referred to a local Division adjudication office.

Answer to Claim for Compensation (WC-22)

An employer/insurer must respond to a Claim For Compensation within 30 days of the date of Claim Acknowledgement Letter, by filing an Answer to Claim for Compensation form (Answer). Division staff processes Answers to Claims in the same manner previously described for processing claims. Copies of the Answer are sent to the employee and the employee's attorney, when applicable.

An employer/insurer must respond to a Claim for Compensation within thirty days on the Form 22. Attempts by the employer to answer the Claim and assert the employer is not liable by a letter, an affidavit or any means other than the Form 22 will be rejected and returned. All corporations must be represented by an attorney in workers' compensation proceedings and the attorney must file the Answer of a corporation. The Division requires the original and three copies of the Answer. Copies are sent to the employee and employee's attorney, if applicable.

Common Mistakes or Problems with Claim for Compensation (WC-21) And Answers to Claim for Compensation (WC-22)

1. If injury has been reported to the Division, injury number not included on the Claim.
2. Injury number not provided on the Answer.
3. Claim or Answer not signed.
4. No social security number provided on the Claim.
5. Insufficient number of copies of the Claim or Answer. Please send the original and three copies, or more copies for each party if there are more than one employer or insurer.
6. An extra copy of Claim or Answer, or self-addressed, stamped envelope not included for individuals requesting a receipt copy.
7. For Claims against the Second Injury Fund, if the Yes box is checked for a Claim the information in items 10 and 11 is not completed. If the No box is checked, the information in items 10 and 11 is included when it should not be filled out.

INFORMATION TECHNOLOGY

The image processing system went into production January 1, 1994, and currently over 3,000,000 documents have been processed. The image processing system provides for the electronic capture, storage, and retrieval of all paper documents submitted to the Division, excluding medical records and depositions unless introduced as evidence at a hearing. All cases for injuries that occurred since January 1, 1994, are processed through the system. An electronic case file is created for each of these cases, replacing the paper file.

The image processing system uses the IBM AS/400 Visual Information Program in conjunction with the Image Plus Workstation Program on personal computer workstations for the indexing, storage, and retrieval functions of the system. Documents are backed up and saved to optical disk each night. A duplicate copy of each optical disk is stored off site for disaster recovery purposes.

With the advent of the image processing system, changes to old procedures and new requirements were necessary. The Division no longer accepts depositions or medical records for scanning to the case file as a matter of course unless they are introduced as evidence at a hearing. Standards were established to insure the readability of the documents through the system. The minimum font size is ten on computer-generated documents, but this may not be acceptable depending on the type of printer used. **No photocopies or faxes can be accepted.** All documents must be submitted on standard 8 ½" X 11" forms. Documents not meeting the minimum standards will be returned. A test document may be submitted for Division approval.

The image processing system provides many benefits to the Division including the following:

- Elimination of lost files.
- Reduced manual paper handling and mailing of files between offices.
- Immediate statewide on-line access to case files.
- A significant reduction in file storage space.
- Reduced the need to "archive" (store) paper files off-site.

If you have questions concerning forms or document quality, or would like to submit a test document, please contact:

Division of Workers' Compensation
P. O. Box 58
Jefferson City, MO 65102-0058
Telephone Number 573-751-4231

Electronic Data Interchange (EDI)

With the imaging system, the Division took major steps to reduce the processing and handling of paper. The Division has continued that trend by taking an active role in the use and development of EDI for workers' compensation. EDI technology replaces paper forms

by using a national standard format for the electronic reporting of workers' compensation data between insurance carriers and the Division. The International Association of Industrial Accident Boards and Commissions (IAIABC), is coordinating the EDI project for workers' compensation. The project began in 1991. The Division currently has 33 entities that report first reports of injury via EDI. In fiscal year 2004, the Division received 106,708 reports, or 75% via EDI. The Division will soon propose a rule that will mandate the electronic reporting of the first report of injury for most reporting entities.

Savings from the use of EDI result from:

- A major reduction and consolidation of the existing paper forms being sent to the Division will reduce paper handling, lost documents, and errors in filing.
- Standardization of data capture across jurisdictions will reduce costs for employers and carriers serving multiple states.
- Improved data quality, maximized personnel resources and reduced data entry requirements.
- The use of coded data rather than textual values will enhance electronic analysis of data.
- Provide timely and accurate reporting, eliminating backlogs that are typical in a paper-based system.

Missouri is a leader in advancing the use of EDI, and was the 14th state to move into production for EDI reporting of the First Report of Injury. The Division has adopted the WC-1-EDI, Release I, as the required format for Report of Injury for both paper and electronic reporting purposes. The Division has also served with the EDI technical committee to assist with the development of EDI standards for the First Report of Injury Release II, and Medical reporting modules.

Missouri is currently in production with multiple trading partners for the 148 (First Report of Injury) and AK1/824 (Electronic Acknowledgment). We have the capability to process both ANSI X12 and Flat File transmissions. Missouri is currently working with three (3) different EDI service providers to provide customers with a choice of traditional or Internet-based EDI. We will continue to work with service providers bringing ongoing test pilots with those carriers, self-insured and third party administrators desiring to participate in EDI. Contact the Division at 573-522-1963 for additional information about EDI.

Automated Integrated Computer System (AICS)

The AICS is the computer system the Division uses to manage its workers' compensation functions. The AICS has been in production since September 1997. It tracks all injury and regulatory actions, as well as most ancillary functions, for the Division.

Some of the information managed through AICS includes the following:

- Complete injury information on all workers' compensation injuries reported since 1986 including permanent total disability and death cases that occurred prior to 1986 where benefits are still being paid.
- Docket case history for all injuries reported.
- Proof of insurance coverage information for Missouri employers.
- Information on all employer/Insurer and Second Injury Fund claims filed.
- Information on all medical-fee disputes.
- Records for all self-insured employers and groups.
- Data on worker's safety site visits and certification of professionals.
- Data on calls received through the toll-free number.
- Statistical Data on injuries and benefits paid.

This is a small sampling of data currently provided through AICS. Most of the individual automated functions formerly used by the Division have been incorporated into AICS, providing the ability to share common information among all users. Data captured through AICS is very extensive and will enhance statistical reporting capabilities.

The AICS will help the Division to meet the current and future information needs of the Missouri Workers' Compensation community.

E-mail

Electronic mail (e-mail) has been implemented in all Division offices throughout the state, greatly improving efficiency. Interfaces have been developed in AICS to work with the State Accounting Management II system developed by the Office of Administration to manage state financial information.

In 2003, the Division implemented its new electronic docket notices system. This system allows parties to workers' compensation cases to receive notices from the Division via email in a format best suited for the recipient. Parties that receive their notices via email get them overnight. The notices can be sent in a .pdf format that appears just like the paper notice or in a data format that the recipient can use in its own computer system. All insurance companies, attorneys, third party administrators, self-insured employers and self-insurance groups may receive such notices. For more information please contact the Division at 573-522-1963.

LEGAL SECTION

Introduction

The Division's Legal Section provides legal support for the various programs and assists in the overall administrative functioning of the Division. The section is responsible for handling legal issues that may affect workers' compensation cases, such as the bankruptcy of employers or the insolvency of insurance companies. The section also works with the Insurance Unit in issues involving self-insurance, such as the collection of security to pay injured workers. The section reviews statutory proposals and is responsible for the administrative rule-making process. The Legal section handles requests for information received by the Division. An overview of how requests for information are generally handled is covered in this manual.

Liens

The Legal Section processes liens for child support and medical services filed with the Division of Workers' Compensation. Liens filed by the Division of Child Support Enforcement are filed electronically and notices are computer-generated. Notice is automatic to the parties. The Division of Child Support Enforcement answers most questions about liens. Private attorneys and individuals may file their own child support liens under § 454.517, RSMo. The Division requires the filing party prepare the Notice of Lien, provide an affidavit stating the amount of child support owed, and a certified copy of the divorce decree or other document on which the child support claim is based. Five copies must be filed with the Division. These applications are processed and the Division mails notice to the appropriate parties in the case.

Medical services liens are liens filed by the State for medical bills paid through Medicaid, Medicare or the Veteran's Administration. These liens are filed directly by the Department of Social Services.

Sunshine Law Requests

The Legal Section handles all Sunshine Law requests. Under Chapter 610, RSMo, the public has access to all public records maintained by the Division. The statute requires that requests must be answered within three business days, or that the Division inform the requesting party that the response cannot be made within that time and give an estimate for the time for response. Because of the complicated nature of most sunshine law requests, it is common for the initial response to state that the request requires further action, and an additional time period will be required to honor the request.

Often, there are questions of confidentiality regarding the release of the requested information. If the information is deemed confidential under the workers' compensation statute or other provision of law, the response will state the basis for the denial of the request including the statutory section that is the basis for the denial. The First Report of Injury, and any subsequent medical reports contained in the case file are confidential records. The Division only releases confidential records pursuant to the Division's rule 8

CSR 50-2.020 (4) (A) through (F). Division rules can be found on the Division's web site at http://www.dolir.mo.gov/wc/. Other documents in the file, such as the Claim For Compensation (Form 21), the Answer to Claim (Form 22), the stipulation for compromise lump sum settlement and the award on hearing are open records.

Any sunshine law request or questions regarding sunshine law requests should be directed to:

Division of Workers' Compensation
Legal Section
PO Box 58
Jefferson City, Missouri 65102-0058

Telephone Calls

Call the local workers' compensation office handling your case if you have general questions regarding a specific case, a procedural matter, or a docket setting. The phone numbers for each local office can be found on the Division's web site.

General questions regarding the workers' compensation law or an administrative procedure, should be directed to the appropriate unit. The phone numbers for each unit are included in the respective section of this manual.

The Division has an employee toll-free information line, 1-800-775-2667 for employee calls about workers' compensation issues. For specific information about a case or to obtain a docket setting, the employee should call the local office handling the case.

The Division also has an employer toll-free information line, 1-888-837-6069, to respond to general questions. Calls regarding administrative procedures will be referred to the appropriate section, and general questions regarding the law will be referred to the Legal Section. Specific questions about programs, including self-insurance, workers' safety programs, or medical-fee disputes should be made directly to those units.

Telephone calls referred to the legal section usually involve questions about the workers' compensation statute, interpretation of case law, a hypothetical fact situation for legal interpretation, or people seeking legal opinion. It is Division policy that a legal opinion cannot be given to the requesting party, whether employee, employer, or insurance company. The Division does not represent any party. Whenever possible, the caller's question will be answered, such as a request for a specific statutory authority for a particular type of action.

Questions relating to insurance policies, rates and premiums for insurance, and other insurance-related issues, are referred to the Department of Insurance. There is, of course, some overlap regarding the issues and where appropriate, the Division will answer the questions.

The most frequent problem faced by the legal section is a request to draw a legal conclusion from the particular fact pattern presented. For example, the section handles numerous calls requesting a determination of whether a relationship between parties is an employer-employee relationship, or an independent contractor relationship. The legal section cannot make determinations such as these, because the request calls for a legal conclusion. However, even if the question cannot be answered, the matter will still be discussed with you, and where practicable, the various factors used in the determination will be explained. When possible, a member of the legal section will discuss the factors involved in the determination to be made. The Division cannot give a legal opinion on this type of question, which may be the subject of dispute later in the worker's compensation case, and ultimately decided by an administrative law judge. The Legal Section may recommend that you consult an attorney to obtain a legal opinion to the inquiry.

Answers to Claim/Extension of Time

Requests for an extension of time to file an Answer to a Claim for Compensation are filed with the Chief Administrative Law Judge in the appropriate local office. The period of time to file an Answer (Form 22) is 30 days from the date the Division acknowledges receipt of the Claim for Compensation. Extensions are only granted for good cause. A request for an extension of time to file the answer should not be made early in the 30-day period. It is appropriate for the party requesting the extension to file the request at the end of the time period to answer the claim. Requests for an extension must be in writing and addressed to the local office handling the claim. Facsimile requests for an extension are also accepted.

Conclusion

This overview of the Legal Section is furnished to educate the workers' compensation community regarding requests for information directed to the Division. The Division's goal is to provide appropriate, helpful information within the bounds of the statute. The Division is working to improve the information, nature and form of requests, by educating the public, as well as staff members, so Division responses will address the issue in an accurate and timely manner.

WORKERS' COMPENSATION CLAIMS PROCESS

The primary function of the Division of Workers' Compensation is to provide prompt and equitable resolution of all cases of work-related injuries and occupational diseases. When the parties to workers' compensation cases must resolve their issues through evidentiary hearings, the costs for injured workers and employers increase considerably. The time needed to prepare for evidentiary hearings, as well as time spent in the appeal process, can significantly delay resolution of cases as well. Therefore, the Division actively promotes the resolution of cases through settlement to reduce time and cost.

The Division's administrative organization is designed to promote fair and equitable settlements between parties with a minimum of litigation. The Division has 48 administrative law judges and legal advisors in eight local offices around the State.[1] The adjudication staff assists employers and workers to settle any disputes that may arise because of the injury.

There are two tracks to help parties resolve workers' compensation cases; the non-contested and contested tracks. The non-contested track is initiated by the employer/insurance carrier's filing of a First Report of Injury. When the worker has been fully released to work, the parties come to a conference setting with an administrative law judge or legal advisor to attempt to resolve outstanding issues, including the payment of permanent partial disability benefits in appropriate cases. The conference is usually conducted with mediation techniques to help the parties reach a settlement agreement. When an administrative law judge or legal advisor approves a written settlement agreement signed by the parties, the case is concluded.

A contested case is initiated by the injured worker filing a **Claim for Compensation** (Form 21) requesting benefits. The claim is usually filed if the injured worker believes the employer/insurance carrier is not paying or providing all required benefits. On this track, the case may be set for a pre-hearing conference, mediation or evidentiary hearing. The pre-hearing conference and mediation are settings designed to resolve the case as quickly as possible. Depending on the local office rules, the pre-hearing conference may be as involved as a mediation.[2]

To minimize the costs for the parties to a case, the Division's mediation services are specifically designed to resolve disputes more quickly and at the same time preserve the rights of all the parties involved. By resolving more cases through the mediation process, the Division's judges are able to schedule hearings more quickly for those cases that truly require a resolution by hearing.

[1] The offices are in Cape Girardeau, Jefferson City, Joplin, Kansas City, Springfield, St. Joseph and St. Louis as mandated by § 287.640.1, RSMo. The Division's St. Charles office is one of the two other offices authorized by this section. The adjudicative staff also conducts dockets at 38 additional locations around the state to meet the statutory mandate that all cases be heard in the county where the accident occurred or and adjacent county. See § 287.640.2.

[2] Offices with only one administrative law judge do not use mediation as extensively as the other offices because the administrative law judge may be disqualified from later hearing the case. See § 287.430. The one administrative law judge offices are Cape Girardeau, Joplin, Springfield and St. Joseph. In these offices, the legal advisor may conduct evidentiary hearings and issue an award as an associate administrative law judge.

The increase in mediations is significant because the resolution of disputes in the earlier stages of a contested case provides benefits more quickly to the injured worker. This procedure also reduces costs for the employer/insurance company and the injured worker that are associated with preparing for a hearing.

The Division has significantly improved the case docketing process since the enactment of SB 251 and the publication of its new administrative rules in 8 CSR 50-2.010 – 2.020. As a result, cases move more quickly through the system; are settled earlier in the process; reduce costs for the parties, often by a significant amount[3]; and provide for more prompt payments of benefits to the injured worker.

Adjudication Offices
Statistics – FY 99 through FY 04[4]

FY	Conf.	Prehearings	Mediations	Settlements	Dismiss	Hearings	Awards[5]
1999	18,627	51,397	20,245	33,438	12,488	859	799
2000	22,005	49,394	21,558	34,151	12,634	940	764
2001	22,849	52,985	23,714	34,620	11,492	895	754
2002	22,663	66,988	24,383	36,397	14,471	927	754
2003	22,880	61,580	24,940	34,639	12,338	924	835
2004	22,593	59,066	21,894	36,485	12,041	886	792

[3] In many situations, the parties are able to settle cases before depositions are taken. This can save hundreds or thousands of dollars per case, depending on the nature of the case.
[4] This table shows the number of settings held for fiscal years 1999-2004. Although the number of reported injuries has declined over the same period shown in the table, the number of settings has generally risen. As a result, the pending caseload has declined.
[5] The number of awards is lower because a number of contested cases settle after the hearing is conducted, either because the administrative law judge has given a preliminary indication of the award that will likely be issued or because the hearing developed issues that encourage the parties to settle.

PROGRAMS

The Division has six specialty units and programs: the Benefits Unit, the Insurance Unit, the Information Specialists Unit, the Dispute Management Unit, the Missouri Workers' Safety Program and the Fraud and Noncompliance Unit.

BENEFITS UNIT

This unit is responsible for Medical Fee Disputes, Physical and Vocational Rehabilitation, Rehabilitation Facility Certification, and Second Injury Fund payment processing. The unit also provides consultation services regarding medical issues to all other Division sections when needed. Three of these programs provide benefit services to injured workers, while the medical fee dispute program assists health care providers and employers/insurers in resolving medical fee disputes and protects employees from being improperly billed.

Medical Fee Disputes

The goal of the Medical Fee Dispute Program is to facilitate the resolution of a medical fee dispute arising between a health care provider and the employer/insurer. There are two types of disputes. The first type of dispute is when the health care provider has been authorized to provide medical treatment by the employer/insurer but is paid only a portion of the bill. The health care provider files an Application for Payment of Additional Reimbursements of Medical Fees form with the Division. In this type of dispute the employer/insurer has typically discounted the bill, and the health care provider is unwilling to accept the discount.

The second type of dispute occurs when the authorized medical services were provided, but the employer/insurer has not paid any of the bills. In this case, the health care provider files a Notice of Services Provided and Request for Direct Pay Application form with the Division. There may be numerous reasons why the employer/insurer decides not to pay the bill. A frequent reason for the dispute is whether the underlying injury is compensable. These types of disputes are tied to the underlying case and resolved when the case is adjudicated.

The health care provider initiates the process by filing one of the application forms. More than one bill that is related to the same injury may be included on the form. A report of injury or claim for the injured employee must be on file with the Division in order for the Division to have jurisdiction to accept the dispute. After the application is accepted, the health care provider must attempt to resolve the dispute with the insurer. This method encourages the resolution of the dispute between the health care provider and the employer/insurer without the intervention of the Division of Workers' Compensation. If the parties are unsuccessful, the Division provides a forum to resolve the dispute. Either party may request an evidentiary hearing. The Division encourages the health care provider and insurer to enter into long-term economic relationships.

Since the workers' compensation law gave responsibility for handling medical fee disputes to the Division of Workers' Compensation in 1992, there have been over 4,698 disputes filed

and 3,088 of these have been successfully resolved. In fiscal year 2004, which ended on June 30, 2004, the medical fee dispute staff received 1,088 applications, 612 for direct pay and 476 for additional reimbursement.

Also in fiscal year 2004, 304 evidentiary hearings were scheduled, with a total of 12 hearings being held. Of the other cases scheduled for hearing, 150 cases were resolved prior to the hearing.

Physical Rehabilitation and Facility Certification

The goal of this program is to restore the injured employee, as quickly and as nearly as possible, to a condition of self-support and maintenance as other able-bodied workers, through physical rehabilitation. Seriously injured employees receiving physical rehabilitation in a facility certified by the Division are entitled to a weekly benefit of forty dollars per week paid by the Second Injury Fund. This does not mean the employee cannot be rehabilitated in other facilities. It does mean, however, if rehabilitated in other facilities, the employee cannot receive the Second Injury Fund weekly benefit. To be certified, the rehabilitation facility must meet criteria and specifications for function, personnel, equipment, quality, and facility adequacy. The Division has recently updated the criteria for certification of compliance to current professional standards. Presently, there are approximately 400 facilities in Missouri certified by the Division of Workers' Compensation.

The physical rehabilitation program staff investigates and determines the employee's eligibility to receive benefits. First Report of Injury forms are reviewed each week to identify those injured employees who may qualify for the additional benefit. When the employee meets the criteria and is receiving services from a certified facility, the Director issues an order for physical rehabilitation and authorizes $40 in weekly payments to be paid to the employee from the Second Injury Fund for up to 20 weeks. In unusual cases, benefits may be provided for up to an additional 20 weeks by special order. Benefits are paid to the employee only while actually being rehabilitated. The program averages 180 active cases at any one time. Each case requires some type of action on a weekly basis. The rehabilitation facility is required to submit progress reports every two weeks while the employee is receiving therapy. The unit works closely with attorneys, employees, insurers, case managers, and therapists.

Vocational Rehabilitation

Employers may use this voluntary program to provide vocational rehabilitation to severely injured employees. The employee must have sustained an injury of sufficient severity arising out of and in the course of employment. The employee may receive vocational rehabilitation services, if authorized by the employer, which are reasonably necessary to restore the employee to suitable and gainful employment.

The Division has the responsibility to ensure qualified practitioners and facilities are available and have the capability of providing the appropriate rehabilitation services for the injuries sustained. The Division also has the responsibility of reviewing the written plan of care to ensure the goal of returning the employee to gainful employment is being

implemented. To conserve resources and reduce duplication of services, the Division has an interagency agreement with the Division of Vocational Rehabilitation in the Department of Elementary and Secondary Education to provide these services.

Second Injury Fund Payment Processing

The Division has responsibility to pay Second Injury Fund (Fund) benefits. When an employee is eligible for benefits and a compromise settlement has been approved or an award has been issued, the Division processes payments to the injured worker.

In fiscal year 2004, payments from the Fund for benefits and expenses totaled $57,135,590.86.

Claims against the Fund for permanent total, permanent partial, lost wages from a second job and uninsured employer medical benefits and death benefits are made by filing a Claim for Compensation form (WC-21) indicating second injury benefits are being sought by the injured worker. In FY 2004, 13,421 claims were filed against the Fund. The Office of the Attorney General represents the Second Injury Fund and the Treasurer of the State of Missouri is the custodian of the Fund.

In pre-hearing conferences, mediations or hearings before the Division, legal advisors and administrative law judges determine eligibility for Fund benefits based upon medical evidence submitted by the employee and the Attorney General's Office. A legal advisor or administrative law judge may approve a stipulation agreement or award benefits payable by the Fund.

When an award or stipulation is issued, the Unit will review it for completeness and enter payment orders in the computer system. Checks are prepared at the Office of Administration, Division of Accounting, and distributed by direct deposit or mail. Direct deposit into bank accounts is a service initiated in December 1994 and available to claimants receiving permanent total or death benefit payments. The Division's Second Injury Fund Payment Processing staff also continually updates addresses and claimants' marital and death status to assure proper payments are made for lifetime settlements or dependent death payments.

Garnishments or liens for child support payments are deducted from benefit payments. Medicaid liens filed by the Department of Social Services, Division of Medical Services, for medical benefits must also be deducted before any medical payments are made to the injured worker.

Claims for physical rehabilitation benefits are paid as ordered by the Division Director from a review of injury and medical reports, or referrals from attorneys, rehabilitation nurses, case managers or claims adjusters. Payments are made upon receipt of executed pay orders prepared by a rehabilitation case specialist and authorized by the Director on the basis of medical reports and confirmed physical therapy appointments as prescribed by the attending physician.

The Second Injury Fund staff also collects surcharge payments from authorized insurance companies and self-insured employers in Missouri. These companies are required to submit a Second Injury Fund Surcharge report on a quarterly basis to the Division of Workers' Compensation. The surcharge payments are made directly to the Division and sent to Department of Revenue for deposit to the Fund. The Second Injury Fund staff verifies the reports for accuracy, ensures they are received in a timely manner, corresponds with insurers if there are discrepancies in the report, enters all information into a surcharge database and prepares deposits for the Department of Revenue. Insurance companies and self-insured employers that do not report or pay the Second Injury Fund surcharge timely are subject to penalties and interest assessed on any amounts owed. Overpayments are credited against any future payments of surcharge to the Fund.

INFORMATION SPECIALISTS

The Missouri General Assembly created an information unit in the Division in 1992. The law requires the Division maintain an 800 number for "employees injured on the job to provide information regarding employee's rights."[1] Employees may call **800-775-2667** to speak with an information specialist. The Division also established a toll-free help line, **888-837-6069**, for employers with questions regarding their rights and responsibilities. The information specialists answer over 3,100 calls per month. Some calls may be referred to other programs or units, or other state and federal agencies based on the nature of the inquiry.

Requests for Information

The Division receives numerous requests for information regarding prior workers' compensation cases. The Division policy for such requests requires filing a form with the Division to release this information. The Authorization to Release Information Form is included in this manual. Filing the Authorization form indicates the employee is consenting to the release to the employer confidential information regarding prior workers' compensation cases. The Authorization form requires the employee's signature be notarized. Also, the dates of employee's signature and that of the notary acknowledgment must be the same. Common problems with the Authorization form include notarizing the employer/ representative's signature rather than the employee signature and the date of the employee's signature and the notary do not match.

Under the Americans with Disabilities Act (ADA) a conditional offer of employment must be made before an employer can request information regarding an employee's prior workers' compensation cases. Therefore, the request form indicates the person, about whom the information is requested, is an employee. Employers should make sure their use of a request for prior workers' compensation cases does not violate the ADA. Depending upon the employer's intended use of the information obtained through this process, there may be a potential violation of the Act. Any questions about this process or the use of this information in the hiring process should be addressed with an attorney.

[1] Section 287.126, RSMo.

DISPUTE MANAGEMENT UNIT

The Division's Dispute Management program was created in 1995. The goal of the program is to provide quick service to employees, employers, insurance companies and third party administrators in resolving disputes which involve temporary issues such as medical treatment, return to work, and temporary disability benefits. The Dispute Management Unit (DMU) works with the parties to the workers' compensation case to assist in finding a resolution to these disputes. Division mediators attempt to improve communications with the parties and use telephone mediations as part of the process to resolve these temporary issues. If a resolution of the temporary issue cannot be achieved, the case is referred to the local office to be set on the docket with an administrative law judge or legal advisor. Permanency issues such as the nature and extent of permanent disability are also referred to the local offices.

Dispute Management is a voluntary process that is initiated by the request of one party to the case. Parties do not need to be represented by an attorney at this level. A case cannot be referred to the DMU if a Claim for Compensation has been filed.

Certain injuries may not have been reported to the Division at the time the party contacts the Division for assistance through the DMU. If the party is the employer, insurance company or third party administrator, a First Report of Injury must be filed before the DMU becomes involved. If the party is the employee, the Division will collect information to initiate a case, called an EDR. Information is obtained about the injury similar to the First Report of Injury. A request is then sent to the employer, insurance company or third party administrator to file its First Report of Injury. The mediator will then work with the parties to the case to resolve any temporary disputes.

A workers' compensation case may be referred to the DMU by contacting the Division at its toll-free hotline numbers 800.775.2667 (employees) or 888.837.6069 (employers).

INSURANCE UNIT

Section 287.280, RSMo, allows employers to meet their workers' compensation liabilities through an alternative method known as self-insurance. When an employer qualifies to become self-insured, they become financially responsible for all workers' compensation liabilities incurred. Self-Insurance has proven to be a cost effective alternative for employers who can assume the financial risk associated with self-insurance.

Two types of self-insurance are allowed under the statute: individual and group. Individual self-insurance requires the employer to be wholly responsible for its workers' compensation liabilities. Only larger employers will meet the requirements. The Missouri Division of Workers' Compensation has stringent requirements that must be met before an employer is granted authority to self-insure. In group self-insurance, employers contribute to a loss fund from which claims incurred by members of the group are paid. Group members share in the group's losses under joint and several liability and may be required to contribute additional funds. If all losses experienced by the group are less than the amount of the loss fund, members may be entitled to a refund. There are two types of trusts; homogenous, where members are in a similar industry type; and heterogeneous, where members' businesses may not be similar but who are fellow members of a trade association or group.

The first authorities to self-insure workers' compensation liabilities were granted in 1936. Of the original authorities that were issued, nine of the entities are still currently self-insured. The first self-insured groups were authorized in 1982. There was significant growth in the self-insurance market in the early 1990's, but that tapered off during the soft insurance market of the late 1990's. With the return of a hard insurance market, inquiries and applications for self-insurance are increasing significantly.

The Division's Insurance Unit is responsible for authorizing and regulating all self-insured entities in Missouri. The unit must ensure that all self-insured employers comply with Chapter 287 RSMo Statutes of Missouri and follow the regulations as established in 8 CSR 50-3.010, revised in November 1996. The unit's primary functions are approval of new self-insured entities, regulation and oversight of existing self-insured entities, including case management, financial and safety audits and administering the proof-of-coverage program.

The first function of the Insurance Unit is to review and approve or deny applications to self-insure. The Division must approve all individuals and groups prior to issuing the self-insurance authority. The process begins with applicants submitting the application along with financial information, historical losses, claims handling procedures, safety policy and company information. For individual self-insured entities, the approval process normally takes 60-90 days. The approval process is somewhat longer for group self-insurers because of the number of employers and group information and records that must be reviewed.

The next step for individual self-insured employers is a meeting among company representatives, third-party administrator and the Insurance Unit. During this meeting the company's submission, operations and procedures are reviewed. The meeting also allows

the unit to ascertain the company's goals, attitudes of management and gain an overall perspective of the company's ability to manage self-insurance.

A financial review is also conducted using the current year's financial statements, as well as the audited financial statements of at least the past four years. Profitability, efficiency, solvency and liquidity ratios are calculated and compared to industry norms.

The application process includes a review by the Missouri Workers' Safety Program (MWSP) of the employer's written safety program with an on-site visit of the employer's facilities on behalf of the Insurance Unit. The purpose is to confirm that the applicant's safety program parallels the nature of the business and that the program is designed to provide a safe work environment and addresses the risks and hazards to the applicant's employees. Management attitudes toward safety and its correlation with workers' compensation affect the ability to self-insure. The company profile is evaluated regarding company direction, management and attitude.

Within 30 days after the receipt of the complete submission by the applicant and the safety report from the MWSP, the Insurance Unit completes its review of the submission including the employer's workers' compensation loss history. A company's ability to self-insure its workers' compensation obligations is determined on the basis of a thorough review of all of the information submitted and other information obtained by the Insurance Unit. If the company has met all regulatory requirements and has presented an acceptable submission, the Division will approve self-insurance status. If the company is denied authority to self-insure, the file is closed. However, the company has the right to appeal the decision or reapply at a later date.

The group approval process begins in the same manner as that of the individual applicant. The application and other documentation are submitted and a meeting is conducted among the Insurance Unit, trust representatives and the claims administrator. During the interview, the Insurance Unit obtains information relating to the trust's objectives, overall attitude, knowledge of those involved regarding the concepts of self-insurance and financial viability. The unit must also determine the nature of the relationship between members and the adequacy of the support system underlying the association. During the approval process, the entire program is reviewed. The economic stability of the applying group and its members is evaluated. As with individual employers, expansion, downsizing, federal regulation, the group and members' safety programs, claims administration, loss history and other factors are evaluated prior to self-insurance authority being granted.

Once all information has been received, a decision is made regarding the acceptability of the proposed group. If the group is denied authority to self-insure, the file is closed. The group has the right to appeal the decision. If the submission is within guidelines, the group will be given the opportunity to self-insure. A second meeting may be required to finalize paperwork.

The Insurance Unit's second responsibility is the regulatory function for existing self-insured entities to maintain their self-insurance authority. The unit collects and examines required data on a timely basis, to ensure that all individual self-insured entities and groups remain

within Division guidelines. The regulatory process occurs in three phases: mandatory reports, maintenance of records and claim administration.

Both groups and individual self-insured employers must report specific information to the Division. Individual self-insured employers file on an annual basis. Trusts are required to report both quarterly and annually. Annual reports provide updated financial data, information regarding claims, payroll, premium and number of employees. The groups must also furnish quarterly financial data, loss runs, board meeting minutes, annual audited financial reports and actuarial studies. Individual self-insured employers must secure a Missouri experience modification factor that is used to provide a comparison of the employer's loss history to employer's of the same industry type and to calculate its workers' compensation administrative tax and Second Injury Fund surcharge. Trusts secure a Missouri experience modification factor for each of its members.

In addition, the unit maintains a listing of all required filings and initiates follow-up procedures with those self-insured entities failing to respond. After receipt, the Division files are revised with the updated information.

The maintenance portion of the regulatory function occurs on an "as needed" basis, and is important for the continuation of authority to self-insure. Individual self-insured employers are required to report expansions, downsizing, plant closings, financial changes and any other conditions that can affect the employer's ability to meet its workers' compensation obligations. A high volume of telephone, electronic and written communication from insurance agents or brokers, claims administrators, risk management personnel, fund administrators, attorneys, bankers and account managers provide data for the day-to-day maintenance of the self-insurer's authority and records. Often the maintenance function involves a change in some aspect of the self-insured's status.

The Division must approve all new group member applications before an employer may join a group, the premium rates and any discounts used by the group and distribution of surplus premium. The Division also administers the termination of individual self-insured employers, group members and groups and monitors their outstanding losses and financial condition. With the Division's prior approval, a self-insured employer or group may change bonding company, escrow bank, excess insurance carrier, trust administrator, claim administrator, and financial institution or accounting firm. The Division reviews all requested changes for compliance with the statute and regulations. Upon approval of the requested change, the unit updates its files and notifies all other Division units and related parties affected by the change.

Finally, the Unit audits the claim administration procedures of self-insured employers and groups. Compliance audits are generally conducted on a random basis. The primary goal of the review is to ensure employees of self-insured entities receive their workers' compensation benefits in a professional and timely manner and to verify the compliance of the employer or group's case management program with the Workers' Compensation Law and the Rules Governing Self-Insurers. A final audit report is issued to the self-insured entity, providing requirements and recommendations for improving its case management process.

The Insurance Unit also conducts complaint investigations and audits. Most complaints are the result of simple oversight or error and are quickly resolved. However, if a pattern of non-compliance is noted, a full compliance audit of the employer or group may be conducted. In addition to the initial safety on-site audits, the Missouri Workers' Safety Program conducts follow up audits of safety programs including on-site visits on behalf of the Insurance Unit. Failure to comply with the requirements of the statute and rules will result in the revocation or termination of an employer or group's authority to self-insure.

The final area of responsibility of the Insurance Unit is administering the proof-of-coverage program. Section 287.090.3, RSMo Statutes of Missouri, provides that, "Any insurance company authorized to write insurance under the provisions of the Chapter in this State shall file with the Division a memorandum on a form prescribed by the Division for any workers' compensation policy issued to any employer and any renewal or cancellation thereof." Until 1998, the WC-75 form was the prescribed method for reporting this information to the Division. Now the Division requires insurers to file proof-of-coverage information by electronic medium. The majority of insurers report this information through the National Council on Compensation Insurance (NCCI). NCCI provides the information to the Division electronically, which saves time and money for both the insurer and the Division. With prior Division approval, insurers may report policy information through electronic data interchange (EDI) using a vendor.

Eliminating manual data entry from the WC-75 forms allows the Insurance Unit to provide better and timelier service in responding to proof-of-coverage inquiries from employers, employees, their representatives, insurers, and Division staff. If insurance coverage cannot be verified through the proof-of-coverage database, the employer is referred to the Fraud and Noncompliance Unit for investigation.

MISSOURI WORKERS' SAFETY PROGRAM

The Missouri Workers' Safety Program (MWSP) was created in 1992 to assist Missouri's businesses in establishing safe and healthy workplaces. Employers requesting assistance were evaluated against a set of certification standards for safety and health programs set forth by the Department of Labor and Industrial Relations. On-site consultations were conducted to evaluate hazards within the workplace against the certification standards. If the employers met the certification standards and reduced their injuries and illnesses, a one-time credit was issued toward their insurance premium.

Legislation in 1993 changed the role of the Missouri Workers' Safety Program (MWSP). The duties of the MWSP expanded to include the certification and annual review of insurance carrier safety programs. Each insurance carrier writing workers' compensation insurance in the state must provide the MWSP a written outline of its safety engineering and management program. This program must be certified for adequacy in providing their required services. The workers' safety program performs random on-site visits with the insured of the insurance companies as a part of the certification and renewal process. The requirements for certification are found in 8 CSR 50-7.040 and 50-7.050.

The MWSP continues to provide Missouri employers with on-site consultation. The unit informs and educates employers about changes in workers' compensation laws and implementation of workplace safety and health programs of benefit to them and their employees. The program's staff of safety professionals offer Missouri employers expertise from a wide variety of educational and professional backgrounds in safety and risk management.

The Safety Program certifies the safety programs of Self-Insured Trusts in accordance with the Self-Insurance Unit rules. This certification helps ensure an equal level of workplace safety and health assistance is provided to both trust members and employers in the common carrier market. The unit provides audit reports, with recommendations to the Self-insurance unit, on safety programs for all new applicants seeking the authority to individually self-insure.

The Program certifies and maintains a registry of safety consultants and safety engineers. The registry provides Missouri employers with a list of safety consultants and engineers that are recognized as having met the State's certification standards. Copies of the registry are available to any Missouri employer upon request.

The Workers' Safety Program plays an important role in educating Missouri employers of the availability of workplace safety assistance. Additional information about the MWSP, and downloadable resource materials, can be found on the program's website at www.dolir.mo.gov/wc/mwsp.

The information beginning on page 40 of this manual , "An Employer's Guide to Workers' Compensation Basics", examines the components of workers' compensation insurance premiums and discusses strategies employers can use to reduce their workers' compensation costs.

This article is informational only and provided as a public service. It is not designed for use as an official document, and should not be used as a reference or to cite law or regulations, the Americans with Disabilities Act or other official laws and rules. Although reasonable efforts have been made to ensure that all information made available is current, complete and accurate, the Missouri Division of Workers' Compensation does not warrant or represent that this information is current, complete and accurate. All information discussed in the article is subject to change on a regular basis, without notice.

Any questions regarding the Workers' Safety Program should be addressed to:

Division of Workers' Compensation
ATTN: Workers' Safety Program
P. O. Box 58
Jefferson City, MO 65102-0058
816-889-6214

FRAUD AND NONCOMPLIANCE UNIT

The Missouri Workers' Compensation Division, Fraud and Noncompliance Unit (FNU) was created by the passage of Senate Bill 251 in the 1993 legislative session. The FNU is responsible for investigating all allegations of fraud or noncompliance involving workers' compensation committed in the state of Missouri.

Statute

The Missouri criminal statute that applies to workers' compensation fraud and noncompliance is § 287.128, RSMo. This statute establishes the FNU and outlines the majority of the violations the FNU are authorized to investigate. Simply stated, **fraud** is a false statement made in an attempt to obtain or deny a benefit as it relates to workers' compensation. The false statement must be about a material fact. In laymen's terms, a **LIE!** Generally, noncompliance occurs when an employer fails to carry workers' compensation in violation of the Missouri workers' compensation law.

Below is a breakdown of the fraud statute, § 287.128, RSMo. This breakdown will help one better understand what the FNU requires before it will refer a case to the Missouri Attorney General's office or local prosecuting attorney's office for prosecution.

WORKERS' COMPENSATION FRAUD

Where's the lie?

As was previously mentioned, a lie must have been told that relates to a workers' compensation benefit before fraud can occur. Most fraud allegations fall under §287.128.1(8), RSMo, which states that one must, "Knowingly make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any benefit;".

The following are key elements, which must be established before the Division will refer a case for prosecution.

A. **Knowingly:** The FNU must establish that an individual intentionally made a false statement. An honest mistake is not a crime. A false statement can often times be established through statements the person made, forms the person completed or personnel manuals the employer provided to its employees.

B. **Make or cause to be made:** The person had to actually make the fraudulent claim or had someone else make the statement on his or her behalf. It does not matter if the statement was oral or written.

C. **Any false or fraudulent material statement or material representation:** The "LIE". There must be a "LIE" for there to be a criminal violation, and not just any lie. It must be material to the injured worker attempting to receive or being denied a benefit. The

following examples help highlight the difference between a “material” lie and a lie that would not constitute a criminal violation.

Other Income

Example of non-materiality: A claimant states that he has no money. In fact, he has several thousand dollars in the bank. You now have a lie, but how is it material to him receiving workers’ compensation benefits? In all likelihood, it is not! An injured worker’s benefits are not affected by his savings account.

Example of materiality: An insurance adjuster or employer asks the injured employee if she is working. The employee says, no. If it is determined that she is employed, while collecting workers’ compensation benefits. You have fraud.

In Missouri, it is not a criminal violation under the workers’ compensation law, to work while drawing temporary total disability benefits (TTD). If you become aware of an injured worker receiving other sources of income you may bring that to the attention of the Administrative Law Judge (ALJ). However, if the claims adjuster, doctor or employer asks an injured worker if she is working and she denies it, you have a good referral for workers’ compensation fraud. Why?

You have a lie that relates to workers’ compensation benefits. If the injured worker is able to work for another employer, why can’t she work for the employer paying the TTD? The employer/insurer may be able to either stop paying or reduce the amount of TTD it is paying the injured worker.

Medical

Example of non-materiality: An injured worker goes to his doctor’s appointment. He claims to be in pain. The doctor prescribes pain medication and places the injured worker on light duty. The light duty consists of no prolonged standing and no lifting over 15 pounds. You find out the injured worker is remodeling his home. You notify the insurance company and they have the injured worker placed under surveillance. The private investigator obtains videotape of the injured worker violating the work restrictions.

Do you have a good fraud case? Probably not!

Why? There is no “LIE”?

No one asked the injured worker what he could or could not do. Everyone has different levels of pain tolerance. It is not a criminal violation for an injured worker to violate his doctor’s work restrictions.

On the other hand, suppose the injured worker told the doctor or nurse that he could not, “even lift a bag of flour …stand for more than 10 – 15 minutes without having to lie down for 1-2 hours and ….could not bend over because the pain is too severe.”

Nonetheless, the videotape shows the injured worker lifting a 4 x 4 post, bending over to pick various items up and working for hours without taking a break. This confirms that the statements made to the doctor or nurse were fraudulent.

Why? You have a LIE! You have specific, articulated statements from the injured worker that are documented in the medical records. The doctor used the injured worker's statements to direct medical care and to place him in an "off work" status. Thus, the injured worker is receiving a benefit (medical care, TTD, etc.); to which he may not be entitled. Lastly, you have videotape that verifies that the statements made to the doctor or nurse were false.

D. **For the purpose of obtaining or denying any benefit:** A material misrepresentation, which the subject knowingly made, is not a crime unless it is for the purpose of obtaining or denying a benefit. For instance, lying to a coworker about the nature or extent of one's injuries is probably not a crime because the coworker has no ability to affect benefits.

It has been the experience of the FNU that the vast majority of injured workers are not committing workers' compensation fraud. The violators are the exception to the rule. In addition, most of the fraud cases referred for prosecution are legitimate injuries. The violation occurred after the injured worker began receiving workers' compensation benefits. So, it is possible that an employer/insurer will owe benefits, even though the FNU referred the person for prosecution.

The following are examples of some of the fraud cases we investigate:

- Altering/forging a no return to work slip.
- Altering/forging a prescription to obtain additional medications.
- Claiming a non-work related injury as work related.
- Denying other sources of income/working while collecting TTD.
- Providing false information to a medical provider, employer and/or insurer about one's physical limitations.
- Providing false/fraudulent information in a workers' compensation deposition.
- Colluding with an employer to either claim a non-work related injury as work related or delaying the filing of the claim until after an uninsured employer obtains workers' compensation insurance.
- Denying prior injuries.

Although not all encompassing, the above examples should assist you in determining if you have a fraudulent workers' compensation claim and if the FNU can assist you through its investigative efforts.

WORKERS' COMPENSATION NONCOMPLIANCE

An employer with five or more employees is required to carry workers' compensation insurance. Employers in the construction industry with one or more employees are also

required to carry workers' compensation insurance. The statute does not differentiate between full-time or part-time employees.

Corporate officers must be counted and insured. Accordingly, an employer who manufactures pallets and has two full-time employees, one part-time employee and two corporate officers is required to carry workers' compensation insurance.

Another misconception is that employees must work in Missouri in order to be counted. The statute does not state five or more "Missouri" employees, rather five or more employees. For example, an employer has businesses in Kansas and Missouri. There are three employees in Missouri and two employees in Kansas. Since the total number of employees is five, the employer is required to carry workers' compensation insurance in Missouri.

There are some exceptions made for small corporations, LLP's, family owned businesses, farms, and other statutory exceptions. Your insurance agent, accountant, lawyer or the Division of Workers' Compensation can explain those to you.

What is the big deal about carrying workers' compensation insurance?

First, if an employer does not carry workers' compensation insurance and an employee suffers a work related injury, she will not receive benefits to which she is otherwise entitled. The injured worker could apply for medical care through the Second Injury Fund, but she will not be able to collect temporary total disability, permanent partial disability, or other workers' compensation benefits to which she may be entitled. In addition, the Second Injury Fund receives its money from a surcharge tax on workers' compensation insurance premiums. Thus, the insured employer is not only covering its employees but the uninsured employers as well.

Secondly, an employer who does not provide workers' compensation insurance has an unfair economic advantage over the employer who does provide the coverage. Thus, the law-abiding employer is financially punished for obeying the law and may not be able to obtain new business, expand or provide better benefits to its employees.

Lastly, it is a criminal violation not to have workers' compensation insurance as required by law. It can be expensive: the greater of $25,000 or twice the premium; and there can be up to one year of jail time.

OTHER AREAS THE FNU INVESTIGATES

A. **Premium Fraud:** If an employer obtains insurance under false pretenses, the FNU will investigate. Generally, the areas in which premium fraud occur are underreporting payroll and misclassifying employees' job titles.

Regardless of what you may have heard, insurance companies do want you to make a good faith estimate on your workers' compensation application under estimated payroll. If you had $300,000 in payroll last year and expect to have the same this year, report that figure. The reported payroll does not have to be exact, but if you report $100,000 in estimated payroll versus $300,000, a premium fraud investigation will probably be initiated.

Misclassifying employees can be as bold as having a roofing business and listing all employees as clerical to claiming your roofers are general carpenters. In both cases, the result is a reduced premium. Unfortunately, it is also a misclassification resulting in a premium fraud referral for prosecution.

B. **Subcontractors:** If you use subcontractors, great! If you have employees, do not list them as subcontractors. Doing this not only opens you up to a possible workers' compensation investigation for noncompliance but also could result in an investigation by the Division of Employment Security and the Missouri Department of Revenue.

C. **Charging employees for workers' compensation:** It is a crime for an employer to charge its employees for any part of the employer's workers' compensation insurance. This can also result if you improperly classify your employees as subcontractors and charge them for the workers' compensation insurance premium charged to you by your insurance company.

D. **Reporting Timelines:** There are specific timelines in which an employer/insurer must report an injury to the Division. The maximum amount of time is ten days. It is a criminal violation not to report an injury or to timely file a First Report Of Injury.

AREAS THE FNU DOES NOT INVESTIGATE

A. It is not a criminal violation for an employer to fire an employee for filing a workers' compensation claim. Nonetheless, the injured worker may have a civil cause of action against the employer and obtain a substantial judgment.

B. It is not a criminal violation for an employer to select an injured worker's medical provider. The statute gives that right to the employer. An employee can select a different physician at the employee's expense.

C. If a doctor rates an injured worker at Maximum Medical Improvement (MMI) it is not a criminal violation for the insurance company to stop paying TTD benefits, unless, of course, an Administrative Law Judge has ordered those payments to be made.

D. It is not a crime for the claims adjuster to be rude to an injured worker or vice-versa. It is not an advisable approach to resolving a claim, but it is not illegal.

E. Injured workers are not required by law to answer their telephone while collecting TTD.

PENALTIES

It is a class "A" misdemeanor for the first fraud offense. The suspect could receive up to one year in jail and a fine of $10,000 or twice the value of the fraud, which ever is greater. A second offense is a class D felony.

The first noncompliance offense is a class “A” misdemeanor, punishable by up to one year in jail and a fine of $25,000 (or twice the premium, which ever is greater). A second offense is a class D felony.

CONCLUSION

This information will assist you in better understanding what is and is not a crime under Missouri’s workers’ compensation fraud and noncompliance statute. Of course, every case is fact specific. If you have questions or need additional information, we are here to assist you. The FNU can be reached at:

Division of Workers' Compensation
Fraud and Noncompliance Unit
PO Box 1009
Jefferson City, MO 65102
1-800-592-6003
www.dolir.mo.gov/wc/fraud

AN EMPLOYERS' GUIDE TO WORKERS' COMPENSATION BASICS

Missouri's workers' compensation law was first enacted on April 30, 1925, and took effect in November 1926, following voter approval. The new law had widespread approval from each political party, management, and labor and obtained voter approval by more than a two-to-one margin. Before the new law was enacted, an injured employee's only recourse for a work-related injury was to sue the employer in civil court. To win a settlement an employee had to prove employer's negligence led to the injury. Employers could prevail if they proved employee negligence led to the injury. These civil cases were often long and expensive. The process often resulted in high settlements or jury awards for prevailing employees with serious injuries, but did little for employees with minor injuries or for employees that could not show employer negligence.

The new workers' compensation law required major concessions by management and labor. Management's concession allowed a no-fault system with fixed maximum benefits in exchange for labor's concession of exclusive remedy. The no-fault system was designed to allow faster recovery for employees who had job-related injuries. The injured employee is not denied compensation simply because of unsafe actions contributing to the injury, but allows compensation for work-related injuries without regard to who was at fault. It also allows employees with minor injuries to receive benefits without lengthy legal proceedings, previously an obstacle. The intent of the no-fault system was to make payment of benefits for work-related injuries a simple administrative procedure without requiring the courts to determine fault.

Labor's concession of exclusive remedy requires employees to file all claims for work-related injuries through the workers' compensation system. The injured employee could no longer file a lawsuit in civil court for these injuries. This provision eliminated the large settlements resulting from employers' unlimited liability in civil cases and required employees to settle claims at compensation rates set by the legislature.

Workers' compensation systems have been in place in all states since 1949. Each states' system is unique, but the characteristics of no-fault and exclusive remedy are universal. Other than these similarities, states vary in their laws and how their workers' compensation systems operate. This summary applies only to the Missouri workers' compensation system, and some of the suggestions made later about how to control costs may not apply in other states. It is important that employers with operations in more than one state familiarize themselves with the workers' compensation laws of each state they do business.

How Are Premiums Calculated?

Understanding how workers' compensation insurance premiums are determined is very important. Many calculations and comparisons are needed in order to customize each employer's insurance premium. These calculations and comparisons ensure employers in low hazard industries pay smaller premiums than do high-hazard industry employers. Employers with fewer claims and good safety records pay less in premiums than do employers with many claims and undesirable safety records.

The National Council on Compensation Insurance (NCCI) keeps statistics necessary to differentiate high and low hazard industries and high and low hazard employers within the same industry. The NCCI combines statistics of hundreds of insurance carriers in several states, including Missouri. Each insurance carrier writing workers' compensation policies in Missouri keeps a claims record for each of its clients. At the end of the policy year for each client, the carrier sends the claims data to the NCCI. This pool of statistics is then used to help calculate experience modifiers, premium rates and occupational classifications codes.

High hazard and low hazard industries are distinguished by the occupational classification codes they are assigned and the manual rate[6] they pay for workers' compensation insurance. The classification code and corresponding manual rate are the first factors used to calculate an employer's insurance premium. If an employer is assigned to a high hazard code such as roofing, trucking or logging, the employer will pay a higher manual rate that employers assigned to a restaurant, clerical or light manufacturing code. Manual rates vary widely from one classification to another and are expressed as a dollar figure per $100 of payroll. It is easier to look at rates, however, as a percentage of payroll rather than per $100 of payroll. For example, $13.71 per $100 of payroll is simply 13.71% of payroll.

Each occupational classification code may either represent entirely different industries or a segment within different industries. For example, Code 2501 – Clothing Manufacturing, represents an entire industry, but Code 8810 – Clerical Office Employees, represents employees within many different industries. There are three classifications considered standard exception codes: Code 8810 – Clerical Office Employees, Code 8742 – Outside Salespersons, Collectors, or Messengers, and Code 7380 – Drivers, Chauffeurs and their Helpers. Standard exception codes can be separated from the employers' main classification code because employees engaged in these jobs are normally not involved in other operations.

After a specific classification and manual rate is assigned to an employer's operations, the manual premium is determined by multiplying the employer's payroll by the appropriate rate. Throughout this article a hypothetical employer, "ABC Trucking", will be used to show how the entire rating system works. ABC Trucking has a $453,000 payroll and is classified as Code 7229 – Trucking-Long Haul. Their manual premium would be 453,000 X 13.71% or $62,106. All employers' worker compensation premiums are based primarily on their manual premium. Adjustments may be made to the manual premium based on certain factors, such as safety, that will be discussed later.

The employer's insurance agent or insurance carrier determines the employer's occupational classification code from the definitions available to them from NCCI for the scope of work performed. These definitions are contained in the Scopes of Basic Manual Classifications manual which insurance agents use to classify their employer clients. Since many occupational classifications are very similar, the applicable code may be difficult to determine. In these instances, an insurance agent or carrier may ask the NCCI to physically inspect a specific employer's operations and make the final classification decision.

[6] The manual rate is the rate per $100 of payroll used by the insurance carrier in each job classification code. There are approximately 680 job classifications in any given year.

Employers should obtain a description of their classification from their insurance agent and familiarize themselves with the code or codes assigned to their businesses. Any employer who feels there are significant differences in the description of an assigned classification code and its actual operations should notify its insurance agent or insurance carrier. The agent can probably explain the discrepancies. If not, the employer should contact the NCCI for an explanation of the assigned classification. If an employer changes its operations substantially, (e.g., by purchasing new equipment) request that the agent or the NCCI re-evaluate the employer's operations for possible reclassification. Employers may appeal a determination of the occupational classification code to the Workers' Compensation Classifications and Determinations Review Board. This Board is housed within the Missouri Department of Insurance and reviews complicated cases involving classification, experience modification, and other workers' compensation insurance problems.

How are Manual Rates Determined?

Each year the NCCI files advisory **loss cost rates**[7] with the Missouri Department of Insurance (MDI). The MDI also publishes advisory loss cost rates. Insurance carriers may use either of these advisory loss cost rates to determine their manual rates or may calculate their own loss cost rates as the basis for these rates. Employers pay premium based on the competitive market rates set by their individual insurance carriers. Deregulation of workers' compensation premium rates began January 1994, and allows insurance carriers to set their own rates in the voluntary market.

The NCCI also files recommended rates for the **assigned risk pool**[8] that the MDI reviews to determine the approved manual rates for the pool. The approved rates are effective for all employers that obtain insurance through the assigned risk pool.

Manual rates in the competitive market vary among insurance carriers. The employer's insurance agent should obtain a minimum of three (3) separate written quotes each year, to ensure the employer is getting the best rates. The MDI provides a rate guide service on the web at http://insurance.mo.gov/consumer/wc/wc.htm. Employers may access this service to view the rates filed by insurance carriers. The service provides a list of the lowest rates for any specific occupational classification in Missouri. The four-digit occupational classification code is necessary to obtain the manual rates filed by each insurance carrier. The list can be limited to a specified number of insurance carriers, can list all carriers that filed a manual rate for that occupation classification and can show the low, high and average rate. The information provides a link on the name of the insurance carrier, with the contact person and telephone number, the manual rate and other relevant information.

The two initial factors affecting the insurance premium are the manual rate and the employer's payroll. The third factor affecting the premium is the employer's experience modifier. The experience modifier is one of the most important components of a company's

[7] Loss cost rates are the portion of the manual rate used to pay workers' compensation benefits including medical and indemnity benefits. It does not include as a portion of the rate any loss adjustment expenses, overhead or profit.
[8] The assigned risk pool is an "insurer of last resort". Since workers' compensation insurance is mandatory for most employers in Missouri, the State requires the pool to insure employers that cannot obtain insurance in the competitive, or voluntary, market.

worker compensation premium. It is used as a multiplying factor of an individual company's manual premium and is often the most effective tool for controlling premium cost.

An average experience modifier is expressed as 1.00 and simply means that a company has average losses and will pay 100% of their manual premium discussed earlier. A higher than average experience modifier would be any number greater than 1.00. A company with a 1.43 experience modifier will pay 143% of its manual premium. This 43% surcharge reflects the higher than average claims which the company has experienced. The experience modifier is not always 1.00 or greater, but can also be lower than 1.00. If a company has an experience modifier of .73, they will pay only 73% of their manual premium. This effectively gives the company a 27% discount, and reflects the employer's lower than average losses, claims and injuries.

The following table compares different experience modifiers for ABC Trucking with varying results.

Table 1
Experience Modifier Effect on Premium

Manual Premium	Experience Modifier	Discount/Surcharge	Modified Premium
$62,106	.73	$16,769 Discount	$45,337
$62,106	1.00	None	$62,106
$62,106	1.43	$26,706 Surcharge	$88,812

As Table 1 shows, the experience modifier has a significant impact as to what a company actually pays for insurance. The difference between the low experience modifier and the high experience modifier, in this example is more than $43,000! Experience modifier ranges are common and can vary significantly. Controlling the experience modifier is essential to reducing and controlling insurance premiums.

Calculating the Experience Modifier

This section discusses the basic method used to calculate the experience modifier. One common misconception concerning the experience modifier is that a high hazard industry will have a high experience modifier and a low hazard industry will have a low experience modifier. This is NOT the case. The experience modifier compares only companies within the same industry classification code. ABC Trucking, for example, is compared ONLY to other trucking companies in Code 7229. It is important to remember that MANUAL RATES vary based upon the hazard level of the industry, whereas the EXPERIENCE MODIFIER is based only a company's performance within its specific industry. Achieving an experience modifier under 1.00 is as much an accomplishment for a restaurant or clerical office as for a construction or logging company.

The easiest way to understand how the experience modifier is determined is to examine the loss ratio of an individual company compared to the expected loss rate for that industry. The loss ratio is the actual losses in dollars for an employer divided by the manual premium for that employer. The expected loss rate is simply the loss ratio expected for a particular

industry multiplied by the manual rate for that industry. (This does not seem right to me. I thought the expected loss rate was the losses in a particular industry divided by the total premium for that industry. What are your thoughts?) The expected loss rate is multiplied by a company's payroll to determine expected losses. If ABC Trucking had 9 claims during their policy year totaling $32,295 and a manual premium of $62,106, their loss ratio would be 52% (32,295 divided by 62,106 = .52 or 52%). The NCCI determines the actual expected loss rates for all classification codes and publishes them each year. Many of the expected loss rates are around 52% of the manual rate. For this reason, assume expected losses of 52% are average for the trucking industry. With this assumption ABC Trucking will have a 1.00 (average experience modifier) because they have a 52% (average) loss ratio.

The next table illustrates how the actual loss ratio and expected loss ratio affects the experience modifier. The "Actual Claims" column represents the claims ABC Trucking Company actually experienced during the policy year. The "Expected Claims" column is the premium multiplied by the expected loss ratio of 52%. This ratio represents $32,295 in expected losses. The following table indicates three (3) separate actual claim totals that produce three (3) separate experience modifiers.

Table 2
Loss Ratio and the Experience Modifier

Premium	Expected Claims	Actual Claims	Actual/Expected	Experience Modifier
$62,106 X 52% =	$32,295	$23,575	$23,575/$32,295 = 0.73	0.73
$62,106 X 52% =	$32,295	$32,295	$32,295/$32,295 = 1.00	1.00
$62,106 X 52% =	$32,295	$46,192	$46,182/$32,295 = 1.43	1.43

The actual calculation of the experience modifier is significantly more complicated than this example, but this should help employers understand the basic calculations used to determine the experience modifier. This is only a shorthand method to explain the experience modifier.

Most importantly, employers should realize that experience modifiers are not arbitrary numbers assigned by the insurance carriers, but instead are calculations based on employers' actual claims history. The NCCI publishes a booklet titled "The ABC's of Revised Experience Rating", explaining the experience modifier calculation in detail. Insurance agents can obtain a copy of the NCCI booklet for their clients. "The ABC's of Revised Experience Rating" and other NCCI publications can also be ordered directly from the NCCI. The resource page at the end of this section lists telephone numbers for NCCI and other organizations.

Each year, an employer's experience modifier is re-calculated using the combined claims history from a three-year rolling period. By using a three-year rolling period, the experience modifier will remain more consistent and eliminate most wide variations from year to year. Each year the rolling period drops off the oldest policy year and adds the most recent policy year. If a company has unusually high claims during one policy year their experience modifier will be affected for three years. However, the effect of the high-claims year will be

stabilized by the experience of the other two years on the period. This stabilizing effect works the same when a company has an unusually low claims year. To effectively lower the company experience modifier, the company must consistently control claims over the entire three-year period of the experience modifier.

The three-year rolling period includes a one-year lag period immediately preceding the actual three-year claims period. The one-year lag period is included because of the difficulty placing an immediate cost on claims resulting from serious injuries. A claim resulting from a serious injury may take several months or even years before it is settled. If ABC Trucking has an employee injured on June 30, 2000 and the insurance policy ends the same day, it would be impossible for their insurance carrier to determine a cost for the claim and apply it to that claim year. Since the experience modifier is required for the new policy beginning the next day, a lag period is necessary. The one-year lag period allows the insurance carrier time to settle and close most claims and more accurately estimate the cost of claims that continue for more than one year.

It is important to remember the lag period when analyzing an experience modifier and when setting goals to reduce it. If ABC Trucking has a year with an unusually high claim it will not be reflected in the next year's experience modifier. It will, however, be reflected in the experience modifier two policy years away. If, for example, ABC Trucking has a claim on July 1, 2000, the first day of their 2000-2001 policy, it will not affect their experience modifier for the policy due on July 1, 2001. The premium for the policy year beginning July 1, 2002, is the first time the employer actually is charged for the 2000 claims.

Management needs to understand the lag year in order to evaluate the effectiveness of their safety programs. Suppose ABC Trucking implemented a successful safety program beginning July 1, 2000, and had no claims for the next two years. It would still be July 1, 2002, before ABC Trucking realized any monetary savings from a lower experience modifier. The full benefits of the safety program wouldn't be realized in the experienced modifier until the policy due on July 1, 2004. Understanding the one-year lag period and subsequent three-year rolling claims period can help management set realistic goals for new or existing safety programs.

To forecast whether an experience modifier will be higher or lower, analyze the oldest or first year on the current record and compare that year to the lag year. The experience modifier will likely decrease if the year dropping off the record had more claims and losses than the lag year. If the drop off year had fewer claims and losses than the lag year, the experience modifier is likely to increase.

An excellent estimate of the next experience modifier can be calculated as much as a year in advance. This can be accomplished using three tools:

1. The most recent loss-run statements.
2. The current experience modifier worksheet, which is available from the NCCI.
3. "The ABC's of Revised Experience Rating", booklet.

An insurance agent should be able to obtain all of these. The booklet will explain how to calculate the experience modifier. This will only yield an estimate, but if the loss runs are

accurate and all the claims are closed, this estimate should be very close to the next policy year's experience modifier. If there are open claims on the loss runs, the estimated experience modifier can be calculated using the insurance carrier's reserves. Insurance carriers rarely underestimate the cost of a claim, so calculations based on a reserve will likely yield an estimated modifier higher than the actual modifier.

It is only possible to lower the experience modifier by implementing a successful safety program and reducing claims over a period of at least two years. However, it takes four complete policy years for the best results in lowering the experience modifier from reduced claims and better safety. There is little a company can do to have an immediate impact on the experience modifier. Patience and consistently controlling claims through safety and proper claims management will have a positive impact, but it does not happen immediately.

New companies are often confused about when they will be assigned their first experience modifier. Companies with first time policies pay their manual premium without the adjustment of the experience modifier. This is the same as having an experience modifier of 1.00 because there is no surcharge for a higher than average claims record and no discount for a lower than average claims record. The first experience modifier will be assigned depending on the size of the first year's policy premium. The NCCI offers the following definition in one of its publications:

> "A risk is eligible for intrastate experience rating when the payrolls or other exposures developed in the last year or last two (2) years of the experience period produced a premium of at least $7,000. If more than two (2) years, an average annual premium of at least $3,500 is required."

An employer with a first time policy receives its first experience modifier after two years, but only if the first year's premium is $7,000 or more. The first experience modifier is applied to the premium on the third insurance policy year. Claims during the first year are used to calculate the experience modifier and the second year is the lag year that was discussed earlier.

If a company's first two policy premiums are less that $7,000 each, but at least $7,000 combined, it will receive its first experience modifier after three years. The first experience modifier is applied to the premium on the fourth insurance policy year. Claims during the first two policy years are used to calculate the experience modifier and the third year is the lag year.

If an employer has an average annual premium less than $3,500, it will not receive an experience modifier. Premiums under $3,500 are considered too small of a statistical sample to accurately measure performance. Employers with premiums less than $3,500 must pay the manual premium that was discussed earlier.

The Comprehensive Safety Program

A Comprehensive Safety Program makes good business sense and is required by federal law. The law is called the Occupational Safety and Health Act of 1970. The Occupational Safety and Health Administration (OSHA) enforces the law. The Missouri Workers' Safety Program is an effective resource that provides on-site assistance to employers to establish workplace safety programs, without the possibility of referral to OSHA for safety violations.

Employers who wish to establish comprehensive safety and health programs should also comply with OSHA standards for workplace safety. OSHA performs four main functions--promulgating or writing standards, education, compliance assistance and enforcement of standards. The best way to know precisely the standards for compliance is to become educated on the OSHA standards, or seek on-site services from a qualified safety professional, the Division of Labor Standards, the Missouri Workers' Safety Program, or the workers' compensation insurance carrier.

An effective occupational safety and health program should include four main elements: management commitment and employee involvement, work site analysis, hazard prevention and control, and safety and health training.

The elements of management commitment and employee involvement are complementary to the core of any occupational safety and health program. Management should clearly state work site policies for a safe and healthy work environment. Management should also establish and communicate clear goals for the safety and health program. Employee involvement is encouraged in the structure and operation of the program to enable employees to commit their insights and energies toward achieving the safety and health program goals and objectives. Management should provide adequate authority and resources to parties responsible for the safety program and hold those parties accountable for meeting their responsibilities. Employees should be held accountable for their responsibilities in the safety program.

A practical analysis of the workplace should be conducted to identify and correct existing hazardous conditions. Safety committees are ideal for performing workplace hazard analysis. The safety committee should consist of employees from each department, especially maintenance. To establish a safety committee, the workplace safety director should seek employee nominees and volunteers from each department and shift. Management must provide the safety committee with adequate time, resources, and support to fulfill their obligations. Safety committees are one of the primary tools that management can implement in a high quality safety and health program. The Missouri Workers' Safety Program can provide videos, safety materials, and speakers to assist with activities and agendas necessary to get safety committees started. Insurance carrier loss control services should also be utilized to help get the safety committee or safety meetings organized correctly.

Safety incentive programs are important tools that should be included in the comprehensive safety program. The incentive program should recognize and reward employees for performing their jobs in a safe and healthy manner. Many companies have tremendous success with incentive programs. The key to success is employee involvement and

teamwork. The incentive program requires both elements to be successful. An incentive program must be carefully drawn up to make sure employees are not prevented from pursuing benefits for legitimate workers' compensation injuries.

Management must be committed to safety before a successful safety incentive program can be implemented. Initially, simply providing pay incentives to employees for not getting injured does not work. Once a safety program has been established, including a safety committee and regular safety meetings, management should establish the incentive program. Management has two important functions in designing an incentive program: setting a budget, and setting the goals to be accomplished. The budget should be reasonable, but adequate enough to show management's commitment. An incentive program can be based on the actual workers' compensation insurance premium, or it can depend on the number of employees and annual accidents the company has experienced. If the experience modifier is high and the company is trying to lower it to save money, then the incentive budget could be a portion of these expected savings.

Management should set the goals of the program. Like the budget, the goals should be reasonable and attainable but require a sincere effort by everybody. A reasonable goal, for example, may be a set length of time with no accidents. This length of time should be directly related to past experience and include a reasonable improvement in performance. The safety committee could provide input to set goals for the safety program. This would encourage employee involvement in addition to soliciting innovative ideas.

After a budget and goals for the incentive program are established, the employees should decide how to distribute the rewards. The rewards could be time off with pay, gift certificates, prizes, or cash. Management should not influence the type of rewards employees prefer. Employees should be involved in choosing their reward as long as the cost is the same and within management's budget.

Incentive programs handled appropriately and timely, can be very effective tools in reducing workers' compensation claims and insurance premiums, and for improving employee relations. Management should remain open to change in the incentive program. Adjusting goals and rewards should be done periodically to keep the incentive program as effective as possible.

Personnel Programs

Most small employers lack the resources to hire full-time human resource directors, however, basic personnel procedures should still be implemented. Procedures should be written, documented, and consistently enforced. Personnel procedures should include interviewing, reference and background checks, discipline, accident reporting, and training.

Job descriptions should be completed for each job and each employee. Job descriptions should focus primarily on the physical requirements of the job such as; work posture, lifting, carrying, tool usage, and the number of hours or fractions of hours each task is performed daily. Job descriptions should also include the daily requirements and responsibilities of the position.

The Americans with Disabilities Act (ADA) is a federal law making written job descriptions essential for most employers. This law applies to employers with 15 or more employees and prohibits discrimination against applicants or current employees with disabilities. The designated physician can utilize written job descriptions in deciding the proper return to work program. Job descriptions can be written with the assistance of an insurance carrier's loss control department or an ADA resource. Many job descriptions, also called job function evaluations, can be prepared in a checklist format, applying to a wide variety of jobs, and requiring a minimum of time to complete.

The ADA only allows background checks or pre-placement physicals to be performed after the employer has offered the applicant a specific position with a specific job description. The job offer can be contingent upon the results of relevant background checks and is often referred to as a contingent job offer. Employers may inquire about the history of the employee's workers' compensation injuries. The Missouri Division of Workers' Compensation provides this information when the employer submits an approved authorization release form, which must signed by the employee. It is the employer's responsibility to comply with all applicable employment laws regarding any inquiry into employee background and work history.

Employers should also contact their designated medical providers or local hospitals for assistance in implementing a drug-screening program. Insurance carriers' loss control services are helpful when establishing drug-screening programs. As with workers' compensation record checks, a contingent job offer must be made before an employer can require an applicant to submit to a drug test under the ADA. Many companies have implemented drug-screening requirements for new applicants and current employees.

Proper accident reporting is extremely important. Proper reporting includes employees reporting injuries to their employers and employers reporting injuries to the insurance carrier. Every company policy should require employees to immediately report all workplace injuries. Timely reporting allows supervisors to provide necessary medical treatment, document the incident, determine the cause of the incident, and correct the problem as soon as possible. Promptly investigating accidents and correcting the cause of the accident demonstrates an employer's concern for employee safety and health, and its intent to provide a safe workplace. Reporting policies should be written and documented to indicate that each employee has been notified of proper claims reporting procedures.

Employers should report all injuries to the insurance carrier as soon as possible. Do not wait for medical bills or doctor's reports before filing the first report of injury. The law requires an employer to notify its insurance carrier within five days after the injury occurs or receiving notice of the injury from the employee. Early reporting of injuries results in better service from the insurance carrier and faster benefits payments for employees.

If an injured employee has lost time from work that should be compensated, it may take weeks to receive temporary total disability benefits from the insurance carrier if the injury is not timely reported. Therefore, the sooner the report of injury is submitted to the insurance carrier, the sooner compensation to the injured employee can begin. The workers' compensation law requires payments be made to the injured employee within two weeks.

Employees do not always understand this process and require constant assistance by the employer. This contributes to better employee and employer relations.

The employer may pay out of pocket claims under $500 in medical costs involving no lost time. The incident must still be reported to the insurance carrier and the Division of Workers' Compensation. This is not a deductible. If the medical expense later goes over $500 or the employee has lost time from the injury, the insurance carrier must reimburse the medical expenses paid by the employer. Injuries incurred where the employer pays the medical bills cannot be used when calculating the employer's experience modifier discussed earlier. The employer should contact its insurance agent to determine the amount of claims, up to $500, they should pay. It does not benefit all companies to pay claims under $500. In many instances, the $500 paid for a claim will be more than the dollar benefit saved on the premium. The insurance agent should provide a close dollar estimate of claims, to be paid, based on individual policies. The employer should evaluate the actual benefit, if any, of paying low dollar claims compared to insurance premiums.

Choosing a Designated Physician

Missouri law allows employers to select the physician or health care provider to treat their injured employees. In many cases, employers allow the insurance carrier to make this choice. The authority to direct medical attention is an important workers' compensation control measure available to employers, and ensures injured employees receive treatment for work-related injuries and illnesses from qualified physicians. Most employers choose a general practitioner or an occupational health physician as their primary care physician. Either of these physicians is capable of treating most injuries and referring serious injuries to proper medical specialists. Employers may choose specific medical specialists such as an orthopedic surgeon. A primary care physician should be notified in advance if referrals to individual specialists are desired.

Several questions need to be addressed when selecting a primary care physician. Some services the company may want to consider are:

1. Where should employees be sent to obtain immediate treatment for emergencies and 24-hour appointments for other injuries or illnesses?
2. How employees injured after office hours are treated; 24-hour clinics or the local emergency room?
3. If an emergency room is used, can fees be negotiated? Is the employee referred to the designated physician for follow up?
4. Will the physician visit the work site? If so, how often? Is the visit included in the contract? Is there an additional charge?
5. How quickly is paperwork returned to the company?
6. Does the physician or clinic have a qualified case manager on staff?
7. Will the physician help develop a modified or light-duty program and recommend its use?

Discussing these issues with a designated medical care provider will provide savings on emergency room visits for non-life-threatening injuries. Employees, who have made prior arrangements with a designated medical provider, should expect prompt medical attention

with an office visit instead of the more costly emergency room visit. Many injuries such as cuts and sprains require prompt medical attention. However, using the emergency room for all types of injuries is expensive. A doctor should advise which type of injury requires emergency room services and which may be treated with an office visit.

Many employers designate a medical clinic with several doctors. Even though there are several physicians to choose from, the employer should try to utilize only one primary physician. Building a close working relationship with one primary care physician is important. Working with one physician regularly simplifies employer and employee requirements for timely paperwork submission and other requirements.

The physician should tour the work facility to better understand the employer's operations. This may be difficult for a small employer, but the offer should still be made. If the primary medical provider has a case manager on staff, these services should be utilized as much as possible. Case managers are usually responsible for following up with injured employees and tracking their progress. Case managers can be invaluable when a return to work program is implemented. They also can encourage and assist injured employees with rehabilitation.

If a particular physician or clinic has been used in the past and has provided quality service, they should be considered when choosing the designated medical provider. Another method of choosing a designated medical provider is to ask an insurance carrier for a list of the carrier's preferred providers and clinics in the area. Medical providers on this list will sometimes offer discounts to clients of particular insurance carriers. A third method of choosing a designated medical provider may be to contact other local business associates for referrals and references.

Choose a physician early during the safety and health program implementation. Notify employees, in writing, that a designated medical provider has been selected and treatment by any unauthorized physician may be at the employee's expense. The insurance carrier should also be informed that a designated medical provider has been selected.

A managed care organization (MCO) is a physician network that provides effective cost containment of workplace injuries and illnesses. Such a network offers employers and insurance carriers discounted rates for medical charges. Since insurance carriers save money when their clients contract with an MCO, the carrier will usually offer the employer a discount off the insurance premium. Many MCOs provide case managers, medical specialists, and additional services such as employee training and safety services. A list of MCOs can be obtained from the Division of Workers' Compensation, the Department of Insurance, or most insurance carriers.

Modified Work Program

One of the main reasons for spending time choosing a designated medical provider is to effectively implement a modified work program. Returning injured employees to modified work as soon as it is realistically possible is very important. It is just as important to allow injured employees to recover sufficiently from their injuries and return to their previous state

of health before returning to work. An effective modified work program will accomplish both objectives.

Two core requirements needed to implement an effective modified work program are written job descriptions and a designated medical provider. The physician must be confident the employer will keep the injured employee within any physical restrictions before an injured employee returns to work. By supplying the physician with a written job description, the physician can better determine if the injured employee can perform the essential job functions. It is important for the employer and medical provider to feel comfortable with each other. Rather than returning an injured employee to a situation of uncertainty, the physician may not return the employee to work at all.

Employers should never give up on complicated cases or write off claims management as unproductive. Regardless of how long a case has continued, the employer should always strive to return the employee to work. It may be necessary to involve the employer's designated medical provider if the employee has been seeing his or her own physician. If this is the case, the employer should contact its designated physician and the employee's current physician to have the treatment for the injured employee transferred.

Injured employees who return to work on modified light duty also benefit. Employees do not receive workers' compensation lost wage benefits for the first three regularly scheduled workdays they are off unless they are off work for 14 days or more. For example, an employee who misses five days of work will be compensated for two days of lost wages, but an employee who misses a full 14 days will be compensated for the entire 14 days. This loss of income to the employee is often compounded by the delay in receiving these benefits from the insurance carrier. Employees and employers are better off if injured employees, where possible, return to work and continue receiving wages on their regular schedule.

Employers should explain this delay to employees who cannot return to work under a physician's orders. It is advantageous for all parties to understand the claims process and the time constraints involved. Additional information on claims procedures can be obtained from the insurance carrier involved or from the Missouri Division of Workers' Compensation.

Knowledge of workers' compensation and safety procedures is invaluable when setting goals to reduce and control workers' compensation costs. Information and on-site services are available from the Missouri Workers' Safety Program and from insurance carriers. Services are available, but it is the employer's responsibility to request services and use them for their benefit. Compensation claims and costs are controllable. Employers who set goals to control claims and costs should realize these goals and many other related benefits.

This article is informational only and provided as a public service. It is not designed for use as an official document, and should not be used as a reference or to cite law or regulations, the Americans with Disabilities Act or other official laws and rules. Although reasonable efforts have been made to ensure that all information made available is current, complete and accurate, the Missouri Division of Workers' Compensation does not warrant or

represent that this information is current, complete and accurate. All information discussed in the article is subject to change on a regular basis, without notice.

Resources

US Department of Labor – OSHA

Kansas City Area Office 6200 Connecticut Avenue, Suite 100 Kansas City, Missouri 64120	816.483.9531
(Missouri Residents Only)	800.892.2674
St. Louis Area Office 911 Washington Avenue, Room 420 St. Louis, Missouri 63101	314.425.4249
(Missouri Residents Only)	800.392.7743

EEOC – Americans with Disabilities Act

St. Louis Office Robert A. Young Federal Building 1222 Spruce St. Rm. 8.100 St. Louis, MO 63103	314.539.7800 800.669.4000
Kansas City Office Gateway Tower II 4th & State Ave., 9th Floor, Kansas City, KS 66101	913.551.5655 800.669.4000
Americans with Disabilities Act (ADA) Project Technical Assistance Center 4816 Santana Circle Columbia, MO 65203	800.949.4232
Department of Insurance Property and Casualty Section P. O. Box 690 Jefferson City, MO 65102-0690 (Consumer Hotline)	573.751.3365 800.726.7390
Department of Labor and Industrial Relations Division of Workers' Compensation Missouri Workers' Safety Program P. O. Box 58 Jefferson City, MO 65102-0058	573.526.3504

National Council on Compensation Insurance, Inc. 800.662.4123
777 Yamato Road
Boca Rotan, FL 33431

Department of Labor and Industrial Relations 573.751.3403
Division of Labor Standards
P. O. Box 449
Jefferson City, MO 65102-0449

DEPARTMENT OF INSURANCE

The Missouri Department of Insurance has an important role in the administration of the workers' compensation law. This section is included in the Division of Workers' Compensation Operations Manual to explain its role in administering the law

The Role of the Department of Insurance

The Missouri Department of Insurance (MDI) Property and Casualty Section reviews workers compensation forms, rules and premium rates submitted by insurance companies to ensure that they comply with state rules and regulations. The Property and Casualty staff is available to assist business consumers with information relating to coverage and premiums and to discuss workers compensation issues.

The Missouri Department of Insurance works with the Division of Workers' Compensation by assessing the workers compensation administrative tax and Second Injury Fund surcharges applicable to the employers who meet criteria established by the Division to self-insure their workers compensation exposure. The MDI also helps the Workers' Compensation Determinations Review Board resolve disputes concerning classifications, experience modification factors, rule interpretation and other issues.

Workers Compensation Insurance Rates

Since deregulation of regular market rates in January 1994, each insurance company sets its own rates, increasing price competitiveness. The Department of Insurance maintains a website that provides information about the compensation rates for each job classification code filed by the insurance companies. Rates are listed by job classification code numbers and can be accessed via the Department's website at http://insurance.mo.gov/consumer/wc.

Rates in the Missouri Workers' Compensation Plan (the so-called "assigned-risk pool") are approved by the Department and are established annually after a public hearing.

The National Council on Compensation Insurance

The National Council on Compensation Insurance, Inc. (NCCI) is a private organization authorized by the Department to collect and maintain statistical data for every employer that purchases workers compensation insurance. The statistical data is used to develop workers compensation loss costs and determine experience modification factors for each employer. The NCCI tracks premiums paid, incurred losses and losses paid under each classification and for each individual policyholder in Missouri. This enables the insurance industry to utilize a standard database of loss information.

Policyholders may request worksheets that contain information used to calculate their individual experience modifications from the NCCI for a small fee. This information will contain the premium and loss information from the NCCI with the data provided by the

insurance company. Sometimes, discrepancies occur that can affect a policyholder's experience modification. Their telephone number is (800) 622-4123.

Insurers can also offer schedule rating, which allows an employer to receive additional credits (or debits) up to 25 percent, based on such criteria as condition of premises, availability of medical care, safety plans or other criteria established by the insurer.

The Missouri Workers' Compensation Plan (Assigned Risk Pool)

Beginning July 1, 1995, Travelers Indemnity Company of Missouri (now known as Travelers Commercial Casualty Company) began underwriting the policies of all businesses that are required to maintain workers' compensation insurance, but cannot find insurance coverage in the voluntary market. For the first time in the U.S., a single insurance company became responsible for providing coverage for all pool business.

The Travelers Commercial Casualty Company assists employers with their workers' compensation safety programs. Its high level of service makes employers more aware of steps that can reduce lost time accidents and the overall cost of claims.

The Missouri Workers' Compensation Plan typically has higher rates than most of the insurance companies writing policies in the voluntary, or regular, market. However, larger employers can receive credits by enrolling in and implementing safety programs developed and monitored by Travelers.

The Missouri Workers' Compensation Determinations Review Board

The Workers' Compensation Determinations Review Board was established during the 1992 Legislative Session. The statute, in § 287.335, RSMo, requires the Board to review:

- Determinations by an insurer or NCCI regarding uniform code classifications.
- Basic Manual Rule interpretations.
- Uniform experience rating plan rule interpretations.
- Calculations of an individual employer's experience rating modification factor.
- Missouri assigned risk plan underwriting rule interpretations.
- Any other related uniform rule interpretations not addressed by MDI rule or regulation.

The Board may:

- Change an employer's classification code or order a new one created.
- Order a recalculation in the employer's experience modification factor if it is calculated erroneously under a formula provided by the Director of Insurance.
- Review code classifications of the individual self-insured employers and self-insured employers in a group insurance arrangement.
- Recommend changes to the present uniform classification system.

If an employer has a problem with a workers' compensation policy, the employer should first try to work out the problem with the insurance company. If the problem cannot be resolved, the employer may file a complaint with the Consumer Services Section of the Department of Insurance. If the problem is still not resolved, the employer may file an appeal with the Missouri Workers' Compensation Determinations Review Board.

Anyone wishing to discuss a potential appeal, ask questions, or obtain further information regarding workers' compensation insurance matters, may contact the Missouri Department of Insurance at:

Missouri Department of Insurance
PO Box 690
Jefferson City, MO 65102-0690
(800) 394-0964 (Toll Free)
(573) 751-3365 (Voice)
(573) 526-4839 (Fax)
www.insurance.mo.gov

Frequently Asked Questions

Q. As an employer, what are the requirements for carrying workers' compensation insurance?

A. According to the Missouri law, workers' compensation coverage is compulsory for all employers that have five or more employees. Partners and sole proprietors may elect to obtain workers' compensation coverage on themselves. Construction industry employers who erect, demolish, alter or repair improvements must carry workers' compensation insurance if they have one or more employees. It does not matter if the employees are full or part-time.

Q. Who is an "employee" under the workers' compensation law?

A. Under the Missouri worker's compensation law, an employee is defined as every person in the service of an employer pursuant to any contract of hire, whether express or implied, verbal or written, or pursuant to any appointment or election, including executive officers of corporations.

Q. Can a corporation be exempt from workers' compensation requirements?

A. A construction corporation is the only corporation that may be exempt from workers' compensation requirements only if there are no more than two owners of the corporation, who are also the only employees of the corporation. It requires filing with the Division a notice of election to withdraw. A corporation that makes this election may withdraw its election by filing with the Division a notice to withdraw the election. The notice is effective thirty (30) days after the date of filing, or at a later date as may be specified in the notice of withdrawal.

Q. What is the period of Limitations to file a claim for compensation with the Division?

A. Under the Missouri workers' compensation law, an employee must file a Claim for Compensation with the Division within two years from the date of injury or last benefit payment made on account of the injury by the employer or its workers' compensation insurance carrier. The period of limitations is extended to three years if the employer/insurer does not timely file the First Report of Injury (FRI) with the Division.

Q. Does the worker's compensation law require an employer to compensate a worker for pain and suffering?

A. No. Pain by itself is not compensable under the workers' compensation law. The worker is entitled to three benefits only under the worker's compensation law: medical, temporary total disability benefits and permanent partial or permanent total disability benefits.

Q. What are the benefits for an injured worker through workers' compensation?

A. Workers' Compensation law provides three types of benefits for a person who is injured while performing work-related duties.

1. **Medical Treatment**: The worker is entitled to receive medical treatment for the work-related injury and does not have to pay for that treatment. The employer or insurer makes payment. But remember the employer has the right by law to select the physician. So if the employee seeks treatment that has not been authorized, the worker may have to pay for that treatment.

2. **Temporary total disability (TTD)**: TTD is compensation for the time the doctor says the worker is unable to work because of the injury. The worker will not receive TTD benefits for the employer's first three regularly scheduled workdays he or she is off unless off work for a total of 14 or more calendar days. Those benefits are calculated at two-thirds of the worker's average weekly wage not to exceed a maximum rate set by the legislature. The average weekly wage is determined according to how the worker's wages are fixed, whether by the week, by the month, by the year or by some other method, such as amount of sales. Temporary total disability benefits cease when the doctor says the employee is able to return to work. Although those benefits are only two-thirds of the average wage, it is important to remember they are tax-free.

3. **Permanent Partial and Total Disability**: Once a doctor has done all he or she feels can be done medically to help the employee, and the worker is not as physically able as he or she was before the injury, then the worker has a permanent disability. And if there isn't anything else the doctor can do to make the worker any better, the disability will be "permanent," meaning the worker will suffer the effect of the injury from that point on. That permanent disability will either be "total" meaning the worker is unable to perform any work, or "partial" which means the worker is able to work but there are limitations or restrictions as to what the worker is able to do. If it is determined the worker is permanently and totally disabled, weekly benefits will continue for the rest of the worker's life. If the disability is a permanent partial disability (PPD), the legislature has established a formula to convert that disability into a dollar amount. The maximum weekly wage amount for a permanent partial disability is less than the maximum for the temporary total disability because the disability is partial instead of total. Compensation is for the disability only.

Q. A worker has been injured on the job, what should the employee do?

A. Prompt reporting by the injured worker is necessary and required by law. Workers should ensure their rights to benefits by providing the employer notice of the injury, no matter how minor. To do that the worker must:

- Report the injury to his or her supervisor as soon as possible, if feasible.

- Tell the supervisor everything about the injury - what, where, when and how it happened.
- Get prompt medical care for the injury.
- Inform the employer about the medical condition and when the worker can return to work if the injury caused the worker to miss work.

Q. A worker has been injured on the job. What should the employer do?

A. The employer should make sure the worker receives immediate medical attention to treat the injury. The employer must report the injury to the insurance company, or the administrator if self-insured, within five days of the date of the injury or within five days of the date on which the injury was reported to the employer if that is later. The insurance company or administrator then reports the injury to the Division.

The employer should report the injury even if it does not believe the injury is work-related. If the employer denies that the injury is work-related, the worker should determine through the employer if the injury has been reported. If the injury has not been reported, call the Division's Toll-free Employee Hotline at (800) 775-2667.

Q. A worker has been fired or threatened to be fired by the employer while the worker was off work because of the injury. Can the employer do that?

A. The answer is maybe. An employer cannot discharge or discriminate against a worker because of a workers' compensation injury. However, if an employer has a legitimate basis for the discharge, such as disciplinary action or work shortage, the firing may be legitimate.

The fact the worker has been fired does not affect eligibility for workers' compensation benefits. If the worker is unable to work, temporary total disability benefits should continue regardless of the underlying work status. If the worker is receiving medical treatment, this should continue. If the worker has a permanent injury, permanent partial disability benefits should be paid in settlement of the case.

The Division does not have jurisdiction over any legal action for a discharge.

Q. Does the employer have to keep the worker's job open while he/she is off work on a work-related injury?

A.The workers' compensation law does not address the issue whether the employer needs to keep the job open while the worker is off work on a work-related injury. The employer and the worker may wish to consult an attorney regarding the applicability of other employment laws to your situation. For information on the Americans with Disabilities Act (ADA) or the Family and Medical Leave Act (FMLA) please call (800) 949-4232.

Glossary

Assigned Risk Pool: Insurance coverage for employers that cannot obtain workers' compensation insurance in the voluntary market. Commonly referred to as the "residual market" or "pool", coverage is provided to otherwise uninsurable employers because workers' compensation insurance is mandatory for most employers. Rates for the insurance are set by the Missouri Department of Insurance. The Travelers is the insurance company currently operating the pool.

Average Loss Cost: Loss cost rates provides an insurer with the portion of a rate not including expenses (other than loss adjusting expenses) or profit. They are based on past aggregate losses and **loss adjustment expenses** projected, through development, to their ultimate value and, through trending, to a future time. The expense and profit components to derive final rates must be added by the insurer, based on its own costs for these items. Average loss costs are the average of the loss costs rates for each class code, weighted by the payroll paid for each class.

Claim for Compensation: A Division of Workers' Compensation form (known as the Form 21) filed by the injured worker claiming workers' compensation benefits. The injured worker's attorney files most claims.

Class Codes: Four digit codes that indicate the type of job classification. Each class code includes a detailed description of the type(s) of work that a group of employees perform. The class codes are used for two purposes: first, the codes are used to determine the premium rate that will apply to an employer's payroll; and second, the codes are used to track workers' compensation injuries for statistical purposes. The Uniform Classification System in Missouri is filed by the NCCI. There are approximately 685 classification codes applicable in Missouri, ranging from clerical to sawmill operators.

Class Types: The primary classification of class codes. There are five class types in Missouri: manufacturing, construction, office/clerical, goods/services and miscellaneous. All class codes fall within one of these five class types.

Competitive Market: The competitive market allows insurers to set their own workers' compensation premium rates based on loss cost data filed by the NCCI or the Missouri Department of Insurance. It is also known as the "voluntary market". Insurers are required to establish rates for a given calendar year and file those rates with the Missouri Department of Insurance by January 30th of that calendar year.

Competitive Market Rate: A manual rate filed by an insurer with the Missouri Department of Insurance indicating the insurer will provide workers' compensation insurance at a particular rate for a particular class code.

Expected Loss Ratio: A loss ratio based on expected losses and income. Expected losses are loss and claim expense projections based on actuarial probability calculations. An insurer uses such projections in the budgeting process. The formula is: (expected

incurred losses + expected loss adjusting expense) ÷ expected earned premiums = expected loss ratio (ELR).

Experience Modifer: The experience modifier is a complicated calculation comparing how a particular employer is faring in regard to its workers' compensation injuries compared to other employers in the same business. The comparison does not cross industry lines; for example, a bank's workers' compensation experience is not compared to that of a logging firm. The formula puts more weight on the frequency of injuries rather than the severity of injuries, although both factors are considered in the calculation. The experience modifier, once calculated, is then applied to the employer's manual premium to determine total premium before discounts.

For example, if an employer's payroll generates $100,000 in manual premium, an experience modifier of 1.15 would generate total premium of $115,000; an experience modifier of .90 would generate total premium of $90,000. This example shows the importance of safety in the workplace to prevent injuries.

Lag Period: The policy year immediately preceding the year for which the experience modifier is being calculated.

Loss Adjustment Expense: The expense involved in settling a loss, excluding the actual value of the loss.

Loss Ratio: A formula used by insurers to relate loss expenses to income. The ratio can also be used to express how much of each dollar of premium is used to pay losses. The formula is: (incurred losses + loss adjustment expenses) ÷ earned premiums = loss ratio.

Manual Premium: Premium developed by the application of the insurer's class code insurance rate per $100 of payroll to the employer's payroll amount in that code.

For example, the insurer's rate for class code 8810 (clerical) may by $.53 per $100 of payroll. Assume the employer is an automobile manufacturing plant with $1,000,000 of clerical payroll. The manual premium is $1,000,000 X ($.53/$100) = $5,300 of manual premium for the clerical payroll. Once similar calculations are made for all payroll by the class codes for that employer, it is added together to determine the total manual premium for the employer. The experience modifier and other changes to premium (such as discounts) are then applied to manual premium to determine written premium.

Manual Rate: The rate per $100 of payroll filed for each class code for which an insurer offers workers' compensation insurance coverage.

For example, a rate of $.53 per $100 of payroll for class code 8810 (clerical) is a manual rate. An insurer that insures all class codes will file a manual rate for all of the approximately 685 class codes in Missouri.

NCCI: The National Council on Compensation Insurance; A national clearinghouse of workers' compensation insurance information for the thirty-eight states for which the NCCI provides some rate filing plan. In Missouri, the NCCI is an advisory organization with

responsibility to annually file trended and untrended loss costs; to implement and maintain the Uniform Classification Codes plan and Uniform Experience Rating plan.

NCCI Uniform Classification Plan: The plan developed and maintained by the NCCI to define the job classifications for workers' compensation purposes in Missouri. Also know as the “class codes”.

Reinsurance Market: Risk transferred from one insurer to another through a contract whereby the assuming insurer (reinsurer) agrees to indemnify the ceding insurer (cedent) for all or part of the claim liabilities under a workers' compensation insurance policy issued by the ceding insurer. The cedent pays the reinsurer a premium. The ceding insurer usually remains liable for claims on the workers' compensation insurance policy, and the reinsurer must indemnify the cedent.

Return on Surplus: The return of investment income on surplus (that is, the amount by which assets exceed liabilities) of the insurer or the insurance industry.

Voluntary Market: See Competitive Market.

Voluntary Market Rate: See Competitive Market Rate.

Written Premium: The amount of an insurer's premiums (other than reinsurance) for policies issued during the year, whether collected or not. The premium in workers' compensation is determined by the application of the experience modifier and other changes to premium (such as discounts) to manual premium for the insured.